

**A POLICY PROPOSAL TO SOLVE THE HEALTHCARE COVERAGE
AND COST CONUNDRUM**

by
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Abstract

The U.S. is an outlier among similarly wealthy countries on two important healthcare metrics: coverage and cost. Despite progress made by the Affordable Care Act, nearly 30 million Americans remain uninsured, translating into worse health outcomes, lower productivity, and shorter life expectancies. And the law did little to constrain health care costs, which are projected to grow twice as fast as the U.S. economy over the next 10 years, threatening to overwhelm federal, state, and household budgets. To identify suitable policy solutions and determine their feasibility, a mixed methods analysis was conducted including a literature review, a case study, and crosstabs. In keeping with the Public Management capstone requirements, this paper was written in the form of a memo to a key policymaker. This memo proposes a new national health insurance program incorporating elements of the Affordable Care Act and Medicaid to achieve universal coverage. While preferential tax treatment of employer health benefits would end, private insurance would not be entirely displaced. A Medicare long-term care benefit would also be created to meet the care needs of older Americans. To address the unsustainable growth in healthcare costs, this memo proposes a new federal entity empowered to set reimbursement rates for all healthcare products and services using a global all-payer budgeting system. These new programs would require \$384 billion in new revenues in the first year and \$4.4 trillion over 10 years, paid for with a payroll tax increase of 8.18 percentage points. This compares favorably with the \$33 trillion cost of single-payer proposals such as Medicare For All. The author concluded that this proposal is plausible from a policy perspective and could garner the political support needed to ensure passage.

Advisor: Paul Weinstein

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Date: May 7, 2019

To: Senator Elizabeth Warren

From: Logan Ruppel

RE: A proposal to achieve universal healthcare coverage while putting national health expenditures on a sustainable path.

Action-Forcing Event

The Robert Wood Johnson Foundation released a study on February 11th, 2019 showing that private U.S. healthcare spending per person is rising twice as fast as GDP per capita, while public healthcare spending is growing much slower, at nearly the same rate as GDP.¹

Statement of the Problem

The two most pressing challenges for the U.S. healthcare system are coverage and cost. But common approaches to expanding health insurance coverage either don't address the high cost of healthcare or require such massive tax increases as to be politically implausible. And typical proposals to address cost can have a negative impact on coverage and on other important priorities such as access to care, consumer choice, and narrowing health disparities among vulnerable populations. This memo seeks to find solutions that address both challenges, expanding coverage to increase socio-economic equity while slowing the growth of overall healthcare system costs. When referenced in this memo, the goal of universal access to health insurance coverage is synonymous with

¹ John Holahan and Stacey McMorrow. "Slow Growth in Medicare and Medicaid Spending Per Enrollee has Implications for Policy Debates." *Robert Wood Johnson Foundation*, February 11, 2019. <https://www.rwjf.org/en/library/research/2019/02/slow-growth-in-medicare-and-medicaid-spending-per-enrollee.html>.

universal affordability of care, because a coverage expansion isn't truly impactful unless it provides value to consumers.

A comparison between the United States and similarly wealthy OECD countries (wealth defined as GDP per capita) reveals that while this group of countries has achieved universal or near-universal health insurance coverage, the U.S. lags significantly behind.² In countries including Germany, Canada, Japan, and the United Kingdom, 100% of the population is covered by some combination of private or public health insurance.³ Conversely, the percentage of Americans covered by any type of health insurance was 86.3% in January 2019.⁴ This might not sound like a significant number, but if 13.7% of the under-65 population is uninsured at any time during the year, that translates into nearly 29 million people.⁵ Prior to implementation of the Affordable Care Act (ACA), the long-term uninsured—defined as not covered at any time over the past 2 years—comprised 60-70% of the uninsured population, though by 2016 the ACA had driven the number down to 53%.⁶ This data shows that a lack of health insurance coverage is not just a function of temporary coverage disruptions or economic fluctuations, but a structural problem that needs to be addressed by public policy changes.

² Rabah Kamal. "The U.S. has the Lowest Insured Rate of all Comparable Countries." *Peterson-Kaiser Health System Tracker*. April 21, 2017. <https://www.healthsystemtracker.org/chart/u-s-lowest-insured-rate-comparable-countries/>.

³ Ibid

⁴ Dan Witters. "U.S. Uninsured Rate Rises to Four-Year High." *Gallup*, January 23, 2019. <https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx>.

⁵ Ibid

⁶ Sara Collins, Herman K. Bhupal, and Michelle M Doty. "Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured." *The Commonwealth Fund*, February 7, 2019. <https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca>.

How Americans are Insured

Over half of all Americans are covered by health insurance funded directly by the federal government, which has a much larger role in paying for healthcare than many may realize. In 2017, 56% of Americans of all ages were covered by private insurance and 36% by public insurance, with the remaining 9% left uninsured.⁷ Of those with private insurance, 49% were covered by group plans through their employer.⁸ Only 7% of Americans purchased plans on the individual marketplaces, 86% of whom received federal subsidies.⁹ On the public side, 21% were covered by Medicaid, 14% by Medicare, and 1% through other public sources such as Veterans Affairs benefits.¹⁰ An additional federal role not reflected in these figures, the Employer-Sponsored Insurance (ESI) Tax exclusion, provides significant support for companies to offer health benefits to their employees in the form of subsidized insurance coverage.¹¹ Notably, after President Trump's inauguration in January 2017, policy changes shifted some people covered under the exchanges into the uninsured population.¹² As a result, this policy proposal and much of the background information featured in this memo use 2017 figures as a baseline to reflect the effects of the ACA as properly implemented.

⁷ Ibid

⁸ "Health Insurance Coverage of the Total Population." *The Kaiser Family Foundation*, 2018. <https://www.kff.org/other/state-indicator/total-population/>.

⁹ Ibid

¹⁰ Ibid

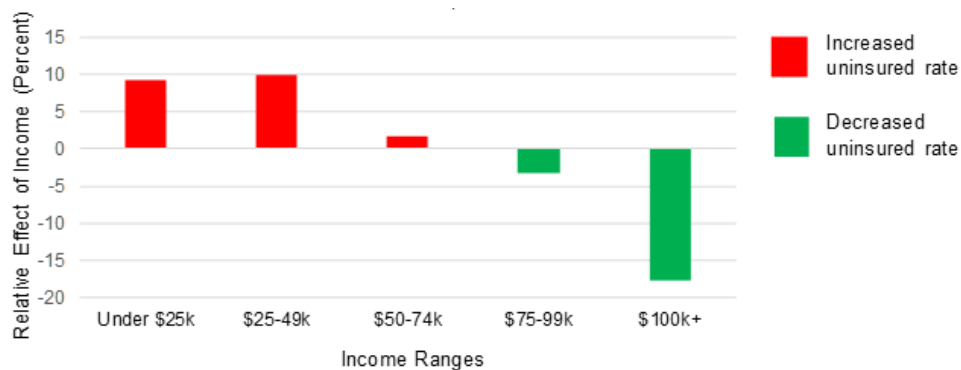
¹¹ Ryan Hill. "Reforming the Employer-Sponsored Insurance Tax Exclusion." *American Action Forum*, August 2, 2012. <https://www.americanactionforum.org/wp-content/uploads/sites/default/files/RyanHillPaper.pdf>.

¹² Dan Witters. "U.S. Uninsured Rate Rises to Four-Year High." *Gallup*, January 23, 2019. <https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx>.

Demographics of the Uninsured Population

According to the Census data from 2017, before effects of the Trump administration's policies were felt, 10.2% of all Americans were uninsured.¹³ The most likely individual to be uninsured is a male Latino aged 26-34, making under \$50,000 per year.¹⁴ In the aggregate, men are 3 percentage points more likely to be uninsured than women, a difference of almost 3 million people. Income is a crucial factor in determining uninsurance. As portrayed in Figure 1 below, individuals living in households making under \$49,000 per year are highly overrepresented in the uninsured population, while those making over \$100,000 are extremely highly underrepresented.¹⁵ Higher incomes appear associated with a lower likelihood of uninsurance, and vice versa.

Figure 1: Effect of Annual Household Income on Uninsured Rate, 2017



Data Source: U.S. Census Bureau¹⁶

By race and ethnicity, 19% of Hispanic Americans, 11% of African Americans, 7% of whites, and 7% of Asian Americans are uninsured.¹⁷ Members of Hispanic and African American populations are more likely to be uninsured compared to other groups largely

¹³ "Key Facts about the Uninsured Population." *The Henry J. Kaiser Family Foundation*, December 7, 2018. <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

¹⁴ Ibid

¹⁵ Ibid

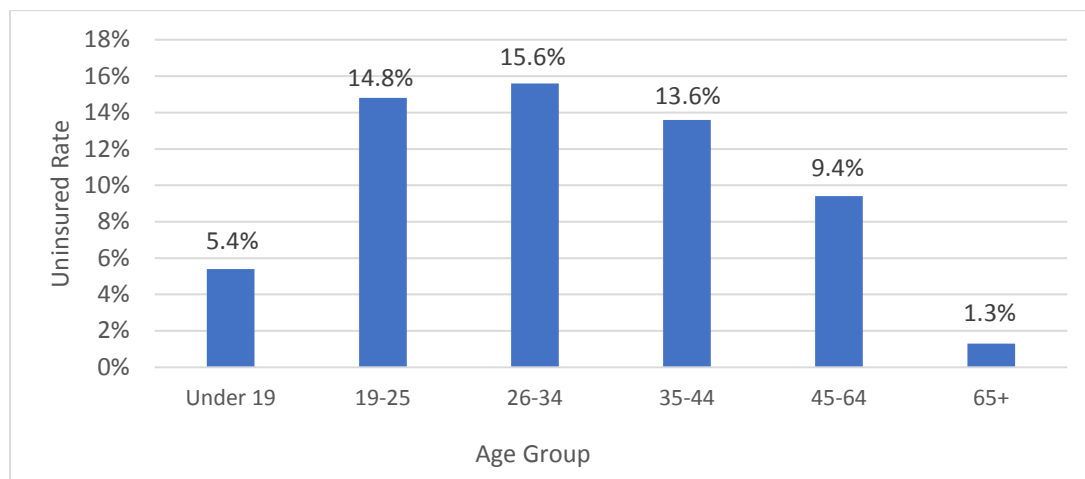
¹⁶ Ibid

¹⁷ Ibid

because they are also more likely to be lower income. Furthermore, Hispanic Americans have the highest uninsured rate, in part because over half of noncitizen immigrants are Latino and noncitizens have significant additional barriers to coverage.¹⁸

In terms of age, those under 19 and over 65 are by far the least likely to be uninsured—children can qualify for CHIP and Medicaid and people age 65 and over generally are eligible for Medicare coverage.¹⁹ As depicted in Figure 2 below, the age group with the highest uninsured rate is 26-34, largely because under the Affordable Care Act, dependents can no longer be on their parents' health insurance plans after age 25.²⁰ Those aged 19-64 generally have higher rates of uninsurance because they are too young to be eligible for Medicare and can only qualify for Medicaid or ACA subsidies if they meet certain income thresholds.²¹

Figure 2: Uninsured Rate by Age, 2017



Data Source: U.S. Census Bureau via Kaiser Family Foundation²²

¹⁸ Jynnah Radford and Abby Budiman. "Immigrants in America: Key Charts and Facts." *Pew Research Center*, September 9, 2014. <http://www.pewhispanic.org/2018/09/14/facts-on-u-s-immigrants/>.

¹⁹ "Key Facts about the Uninsured Population." *The Henry J. Kaiser Family Foundation*, December 7, 2018. <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

²⁰ Ibid

²¹ Ibid

²² Ibid

Significant variation in uninsured rates exists across different states and regions. In states that expanded Medicaid coverage eligibility under the Affordable Care Act, the average uninsured rate is 6.5%, while in states that opted not to expand Medicaid the average is 12.2%.²³ States in the South are the least likely to have expanded Medicaid and as a result the region has a disproportionately high uninsured rate.²⁴

This data suggests that despite the availability of publicly funded or subsidized health insurance options, lower- and middle- income Americans still struggle to afford coverage. More analysis of the factors contributing to the lack of insurance coverage is available in the *History and Background* section of this memo.

Why Access to Care is Important

Access to affordable health insurance and to healthcare itself matters. In the aggregate, increased access to care means a healthier population with longer life expectancies and higher economic productivity.²⁵ At the individual level, uninsured people are less likely to utilize preventative care and to seek care in general for major illnesses and conditions, leading to worse health outcomes.²⁶ When uninsured people (and those with insufficient coverage) do access needed care, they often struggle financially to make ends meet.

According to a Kaiser Family Foundation Survey, nearly two-thirds of the uninsured are

²³ Ibid

²⁴ Ibid

²⁵ John McDermott. "Both in rich and poor countries, universal health care brings huge benefits." *The Economist*, April 28, 2018. <https://www.economist.com/special-report/2018/04/28/both-in-rich-and-poor-countries-universal-health-care-brings-huge-benefits>.

²⁶ "Overview of Quality and Access in the U.S. Health Care System." *Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services*, July 2017. <https://www.ahrq.gov/research/findings/nhqrdr/nhqrdr16/overview.html>.

worried about paying bills if they get sick.²⁷ Furthermore, twice as many uninsured people reported having problems paying or being unable to pay a medical bill when compared to insured people.²⁸ It is for these reasons that adequate health insurance coverage has been shown to improve the financial security of low- and middle- income individuals and families.²⁹

Employer-Sponsored Health Insurance

Half of all Americans—over 155 million people—are covered by employer-sponsored insurance (ESI) plans.³⁰ Before the last ten years or so, ESI was almost always a good deal for workers, but as a recent Commonwealth Fund study put it, employers have responded to rising healthcare costs by “trying to limit their exposure... shifting more of those costs to their employees.”³¹ As a result, workers are seeing smaller annual raises and higher out-of-pocket healthcare costs.³² Because ESI plans are subject to less regulation than Medicare, Medicaid, or ACA marketplace plans, employer-covered households may not be adequately protected from healthcare costs. In fact, one-quarter of ESI-covered households are underinsured, defined as paying annual premiums worth

²⁷ "Key Facts about the Uninsured Population." *The Henry J. Kaiser Family Foundation*, December 7, 2018. <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

²⁸ Ibid

²⁹ Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Samantha Artiga. "The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review." *The Kaiser Family Foundation*, March 28, 2018. <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/>.

³⁰ Joseph Antos. "Capping the Tax Exclusion Will Not Destroy Employer Health Insurance." *Forbes*, April 26, 2014. <https://www.forbes.com/sites/realspin/2016/04/26/capping-the-tax-exclusion-will-not-destroy-employer-health-insurance/>.

³¹ David Blumenthal. "The Decline of Employer-Sponsored Health Insurance." *The Commonwealth Fund*, December 5, 2017. <https://www.commonwealthfund.org/blog/2017/decline-employer-sponsored-health-insurance>.

³² Josh Bivens. "The unfinished business of health reform." *Economic Policy Institute*, October 10, 2018. <https://www.epi.org/publication/health-care-report/>.

10% of their income or 5% for those with lower incomes.³³ The Commonwealth Fund also found that “underinsured adults reported health care access and medical bill problems at nearly the same rates as adults who lacked coverage for part of the year.”³⁴ Clearly, merely being insured does not guarantee adequate access to care.

While some employers provide inadequate coverage, others offer overly generous and costly plans which result in significantly higher healthcare spending.³⁵ The ESI tax exclusion—the third largest healthcare-related item in the federal budget after Medicare and Medicaid—incentivizes employers to increase employee health benefits rather than raise wages, because the former is untaxed.³⁶ Many economists point out that the exclusion disproportionately benefits higher-income people and displaces tax revenues that could be used for other policy priorities.³⁷

An unintended consequence of the employer-centric health insurance system is the phenomenon of “job lock” wherein a worker is forced to limit her or his career ambitions for fear of not being able to afford health insurance coverage after leaving a job.³⁸

The High Cost of Healthcare

The U.S. spends double per capita on healthcare compared to the average comparably wealthy country and the problem is only getting worse. Overall private and public

³³ David Blumenthal. "The Decline of Employer-Sponsored Health Insurance." *The Commonwealth Fund*, December 5, 2017. <https://www.commonwealthfund.org/blog/2017/decline-employer-sponsored-health-insurance>.

³⁴ Ibid

³⁵ Auxier, et al. "What is the Cadillac Tax?" *Tax Policy Center*, 2018. <https://www.taxpolicycenter.org/briefing-book/what-cadillac-tax>.

³⁶ Joseph Antos. "Capping the Tax Exclusion Will Not Destroy Employer Health Insurance." *Forbes*, April 26, 2014. <https://www.forbes.com/sites/realspin/2016/04/26/capping-the-tax-exclusion-will-not-destroy-employer-health-insurance/>.

³⁷ Ibid

³⁸ Dean Baker. "Job Lock and Employer-Provided Health Insurance." *AARP Public Policy Institute*, March 27, 2015. <http://www.aarp.org/ppi/info-2015/job-lock-and-employer-provided-healthcare.html>.

healthcare expenditures in the U.S. are rising much faster than costs for other goods and services. For example, in 2016 healthcare costs rose by 3.9%, nearly double the rate of overall price inflation that year, 2.1%.³⁹ Consequently, healthcare costs as a percentage of GDP are rapidly increasing, from 10% in 1984 to over 17% by 2017.⁴⁰ This is an unsustainable trend—health costs will eventually crowd out other priorities and exacerbate annual budget deficits—and therefore any solution to healthcare access and affordability must consider the costs to all payers and consumers of care.

Long-term Care is Healthcare

Over the next 30-40 years, the number of Americans 65 and older will increase by 80%, while the “oldest old” above age 85 will nearly quadruple.⁴¹ But while the aging of the population is a significant driver of overall healthcare spending, the effects of this demographic trend are much more acute when it comes to long-term care spending (the broader story behind high healthcare costs is further discussed in the *Policy Analysis* section of this memo). According to AARP, long-term care (LTC) consists of “assistance with activities of daily living... for individuals with disabilities who cannot perform these activities on their own due to a cognitive, physical, or chronic health condition.”⁴²

Because Medicare does not cover long-term care costs, Medicaid has become the payer of last resort for the nearly 12 million Americans who have long-term care needs, the

³⁹ "Consumer Price Index (CPI) Databases." *U.S. Bureau of Labor Statistics, U.S. Department of Labor*, 2019. <https://www.bls.gov/cpi/data.htm>.

⁴⁰ Rabah Kamal and Cynthia Cox. "How has U.S. Spending on Healthcare Changed Over Time?" *Peterson-Kaiser Health System Tracker*, December 10, 2018. <https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/>.

⁴¹ Melissa M. Favreault, Howard Gleckman, and Richard W. Johnson. "Financing Long-Term Services and Supports: Options Reflect Trade-Offs for Older Americans and Federal Spending." *Health Affairs*, December 26, 2015. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1226>.

⁴² Vivian Nguyen. "Fact Sheet: Long-Term Support and Services." *AARP Public Policy Institute*, March 2017. <https://www.aarp.org/content/dam/aarp/ppi/2017-01/Fact%20Sheet%20Long-Term%20Support%20and%20Services.pdf>.

majority of whom are over age 65 (approximately 40% are younger people with disabilities).⁴³ As a result, 30% of Medicaid's annual budget is spent on long-term care and half of this spending, or \$84 billion, funds care for "dual-eligibles," who are beneficiaries of both Medicaid and Medicare.⁴⁴ Older people are the primary consumers of long-term care because functional disability tends to increase with advancing age.⁴⁵ And long-term care is extremely expensive, especially for people with more severe needs and for any care provided in the institutional (i.e. nursing home) setting. Solutions for long-term care funding must be included in any comprehensive healthcare reform because ultimately, LTC is healthcare. Long-term care needs cannot be disentangled from the strictly medical needs of an aging population because though delivery methods and services rendered are often different, the same people and programs are exposed to the potentially catastrophic costs. And these costs threaten to overwhelm those who need the care, the millions of unpaid caregivers, and Medicaid, which pays for nearly half of all LTC spending.⁴⁶

In the face of such costs, many older people see no option other than spending down a lifetime of earnings in order to meet Medicaid's asset and income limits.⁴⁷ However, there is no guarantee that everyone will need LTC—nearly half of those who spend down

⁴³ "Dual Eligible Beneficiaries." *Medicare Payment Advisory Commission*, June 2016. <http://www.medpac.gov/docs/default-source/data-book/june-2016-data-book-section-4-dual-eligible-beneficiaries.pdf?sfvrsn=0>.

⁴⁴ Steve Eiken, Kate Sredl, Brian Burwell, and Angie Amos. "Medicaid Expenditures for Long-Term Services and Supports in FY 2016." *Center for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, May 2018. <https://www.medicaid.gov/medicaid/lts/downloads/reports-and-evaluations/lts expenditures 2016.pdf>.

⁴⁵ Vivian Nguyen. "Fact Sheet: Long-Term Support and Services." *AARP Public Policy Institute*, March 2017. <https://www.aarp.org/content/dam/aarp/ppi/2017-01/Fact%20Sheet%20Long-Term%20Support%20and%20Services.pdf>.

⁴⁶ Ibid

⁴⁷ Tumlinson et al. "Medicaid Spend Down: Implications for Long-Term Services and Supports and Aging Policy." *The Scan Foundation*, March 20, 2013. https://www.rti.org/sites/default/files/resources/tsf_ltc-financing_medicaid-spend-down-implications_wiener-tumlinson_3-20-13_0.pdf.

to qualify for Medicaid don't use any benefits.⁴⁸ Conversely, others forgo needed long-term care to avoid relying on Medicaid and to preserve their savings for other priorities such as passing an inheritance to family members.⁴⁹ When it comes to demographic trends, African Americans and Hispanics are more likely than whites to spend down their assets to qualify for Medicaid long-term care services.⁵⁰ Also, over half of those who spent down in recent years had incomes under \$39,000 while just 15% made \$120,000 or more.⁵¹ This data shows that Medicaid provides a vital backstop not only for traditional healthcare needs, but for the long-term care needs of people across different income levels and racial and ethnic groups.

A more equitable LTC system would enable older people to utilize some of their own savings to pay for care while limiting their exposure to potentially unlimited costs. The clear answer, as with traditional healthcare, is risk-pooling via insurance. A private long-term care insurance market does currently exist, but premiums are unaffordable for most people because the industry underestimated the number of policy holders who would claim benefits, as well as the severity of their needs.⁵² A public program to complement the private plans could help stabilize premiums by providing some certainty to the insurance companies.

⁴⁸ Tumlinson et al. "Medicaid Spend Down: Implications for Long-Term Services and Supports and Aging Policy." *The Scan Foundation*, March 20, 2013. https://www.rti.org/sites/default/files/resources/tsf_ltc-financing_medicaid-spend-down-implications_wiener-tumlinson_3-20-13_0.pdf.

⁴⁹ Ibid

⁵⁰ Ibid

⁵¹ Ibid

⁵² Ibid

History and Background

History of Health Reform

Achieving universal health coverage in the United States has been a century-long saga of missed chances, occasional progress, and frequent accusations of socialism. The story begins in 1883, when center-right German Chancellor Otto von Bismarck successfully pushed for the world's first national health insurance law to mitigate a growing domestic socialist movement.⁵³ Bismarck failed to contain his socialist opponents (they founded the Social Democratic party, one of two major political parties in Germany today) but he incidentally helped catalyze a dramatic shift among most wealthy countries towards government taking responsibility for achieving universal health coverage.⁵⁴

The debate over universal health insurance coverage in the U.S. began in the early 1900s, inspired by Germany's example and made urgent by the rapidly increasing costs of new healthcare technologies ushered in by the industrial revolution.⁵⁵ These pressures came to a head during the 1912 presidential election, when Teddy Roosevelt ran for a non-consecutive third term under the "Bull Moose" party. Roosevelt focused his campaign on progressive issues including a national health insurance plan, but his loss to Woodrow Wilson ended any momentum for health reform at the time.⁵⁶

By the end of WWI in 1919, Americans were wary of any policy proposals originating from their recent enemy, Germany. And the Russian Revolution two years prior had

⁵³ Lorraine Boissoneault. "Bismarck Tried to End Socialism's Grip—By Offering Government Healthcare." *Smithsonian Magazine*, July 14, 2017. <https://www.smithsonianmag.com/history/bismarck-tried-end-socialisms-grip-offering-government-healthcare-180964064/>.

⁵⁴ Ibid

⁵⁵ Forrest A. Walker "Americanism Versus Sovietism: A Study of the Reaction to the Committee on the Costs of Medical Care." *Bulletin of the History of Medicine*, 1979. <http://www.jstor.org/stable/44450946>.

⁵⁶ "National Health Insurance—A Brief History of Reform Efforts in the U.S." *The Kaiser Family Foundation*, March 2009. Published online January 2013. <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7871.pdf>.

begun stoking fears of socialism which would loom over a century of U.S. health reform debates.⁵⁷ The Great Depression of the 1930s again brought concerns over healthcare coverage to the forefront. Millions of Americans were suffering and policy makers responded by exploring ways to improve their citizens' lives. In fact, a universal national health insurance program was nearly included in President Franklin Roosevelt's New Deal as part of the Social Security Act of 1935.⁵⁸ However, doctors' groups such as the American Medical Association (AMA) rallied against the proposal, lobbying accusations of socialism and ensuring the plan's removal from the bill before it was passed.⁵⁹ FDR planned to push for universal coverage again in 1940, a highly popular position, but WWII intervened.⁶⁰

Upon taking office after FDR's death, President Harry Truman made another attempt at achieving universal health coverage, but once again groups such as the AMA raised the specter of socialism and the proposal was tabled indefinitely.⁶¹ Accusations of socialism were particularly damning in the 1950s, considering the intensification of the Cold War with the Soviet Union at the time.⁶² Another reason Truman's proposal failed was the wider availability of employee health benefits, which diminished the need for publically-funded insurance coverage. During World War II, the government-mandated wage and price controls exempted employer-sponsored health insurance, prompting employers to

⁵⁷ Forrest A. Walker "Americanism Versus Sovietism: A Study of the Reaction to the Committee on the Costs of Medical Care." *Bulletin of the History of Medicine*, 1979. <http://www.jstor.org/stable/44450946>.

⁵⁸ Stephanie Buck. "Universal Health Care was almost Part of the Original Social Security Act of 1935." *Timeline*, June 15, 2017. <https://timeline.com/social-security-universal-health-care-efe875bbda93>.

⁵⁹ Ibid

⁶⁰ Ibid

⁶¹ "National Health Insurance—A Brief History of Reform Efforts in the U.S." *The Kaiser Family Foundation*, March 2009. Published online January 2013. <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7871.pdf>.

⁶² Ibid

shift wage increases into health benefits.⁶³ And in 1954, Congress further entrenched the model of health insurance as a job benefit when it created the employer-sponsored insurance tax exclusion.⁶⁴

After healthcare reform efforts faltered in the 1930s, 40s, and 50s, advocates pivoted away from universal programs towards providing coverage for the most vulnerable Americans. By focusing on specific populations, these proposals may have dodged the claims of socialism that plagued earlier attempts. President Lyndon Johnson's Great Society initiative of the mid- to late-1960s led to the creation of Medicare and Medicaid, extending health insurance coverage to older and lower-income people, respectively.⁶⁵ These reforms were passed despite opposition from the AMA, which advocated vigorously against the passage of both laws.⁶⁶

These coverage expansions occurred within the context of the Civil Rights Movement and its goal of social and economic equality for African Americans and other racial and ethnic minorities. As Martin Luther King, Jr. himself once said, "Of all the inequalities that exist, the injustice in health care is the most shocking and inhuman."⁶⁷ Just as buses, schools, and lunch counters were once segregated, so were hospitals and physician's offices. African Americans were also largely excluded from the types of jobs likely to

⁶³ Aaron E. Carroll. "The Real Reason the U.S. has Employer-Sponsored Health Insurance." *The New York Times*, September 5, 2017. <https://www.nytimes.com/2017/09/05/upshot/the-real-reason-the-us-has-employer-sponsored-health-insurance.html>.

⁶⁴ Ryan Hill. "Reforming the Employer-Sponsored Insurance Tax Exclusion." *American Action Forum*, August 2, 2012. <https://www.americanactionforum.org/wp-content/uploads/sites/default/files/RyanHillPaper.pdf>.

⁶⁵ Stephanie Buck. "Universal Health Care was almost Part of the Original Social Security Act of 1935." *Timeline*, June 15, 2017. <https://timeline.com/social-security-universal-health-care-efe875bbda93>.

⁶⁶ Judith Graham. "'Like a slap in the face': Dissent roils the AMA, the nation's largest doctor's group." *Stat News*, December 22, 2016. <https://www.statnews.com/2016/12/22/american-medical-association-divisions/>.

⁶⁷ Vann Newkirk. "The Fight for Health Care has always been about Civil Rights." *The Atlantic*, June 17, 2017. <https://www.theatlantic.com/politics/archive/2017/06/the-fight-for-health-care-is-really-all-about-civil-rights/531855/>.

offer health benefits.⁶⁸ Vann Newkirk, a contributor to *The Atlantic* magazine, wrote “it’s no coincidence or secret that those left out (from the proliferation of employee health benefits) were more likely than not to be people of color.”⁶⁹ In other words, job-based insurance was an effective way for a pre-Civil Rights movement America to exclude its black citizens from the healthcare system. Furthermore, white Americans may have been less supportive of universal government-provided insurance if it meant black Americans would be covered as well.

It was clear to the activists of the era that integrating the healthcare system was crucially important to achieving racial equality.⁷⁰ And so, it was likely by design that the combined force of Medicare, Medicaid, and the Civil Rights Act of 1964 (passed just one year earlier) had the effect of ending segregation in hospitals and much of the broader healthcare system. A new public revenue stream was created to fund Medicare and Medicaid, and the Civil Rights Act banned all recipients of federal funding from discriminating on the basis of race, color, or national origin.⁷¹ As a result, if health providers wanted to access this new, lucrative payment source, they could no longer choose their patients on the basis of race.⁷² But despite this significant progress, disparities in healthcare access and outcomes between white Americans and members of other racial and ethnic groups persist to this day.⁷³

⁶⁸ Vann Newkirk. "The Fight for Health Care has always been about Civil Rights." *The Atlantic*, June 17, 2017. <https://www.theatlantic.com/politics/archive/2017/06/the-fight-for-health-care-is-really-all-about-civil-rights/531855/>.

⁶⁹ Ibid

⁷⁰ Ibid

⁷¹ U.S. Congress. "Civil Rights Act of 1964." *U.S. Code of Federal Regulations*, July 29, 1966. Published online July 7, 2011. <https://www.govinfo.gov/content/pkg/CFR-2011-title28-vol1/xml/CFR-2011-title28-vol1-part42-subpartC.xml>.

⁷² Ibid

⁷³ Vann Newkirk. "The Fight for Health Care has always been about Civil Rights." *The Atlantic*, June 17, 2017. <https://www.theatlantic.com/politics/archive/2017/06/the-fight-for-health-care-is-really-all-about-civil-rights/531855/>.

In the early 1990s, the U.S. elected its first Democratic president since the 1970s, Bill Clinton, and the debate over government's role in healthcare resurfaced. President Clinton had made healthcare reform a major focus of his campaign and once in office, the issue was spearheaded by first lady Hillary Clinton.⁷⁴ However, the universal national insurance plan the Clintons' fought for ultimately failed under pressure by the health insurance and pharmaceutical industries.⁷⁵ A health insurance trade group aired a series of particularly effective ads featuring a fictional couple named Harry and Louise, who sat at their kitchen table bemoaning the problems with government-run healthcare.⁷⁶ The Clinton Administration later refocused its health reform efforts on children, securing passage of the Children's Health Insurance Program (CHIP) in 1996, expanding coverage to millions of children.⁷⁷

A separate Clinton-era reform attempted to reign in rapidly-rising provider reimbursement rates. Passed in 1997, the Sustainable Growth Rate (SGR) formula dictated that annual spending on Medicare physician services would grow no faster than GDP.⁷⁸ By 2002, SGR had cut provider reimbursements by nearly 5% and the ensuing political pressure caused Congress to repeatedly block the formula's effects for the next

⁷⁴ Matthew Holt. "Why Hillarycare failed...and what we need to learn from that failure." *The Health Care Blog*, August 14, 2018. <https://thehealthcareblog.com/blog/2018/08/14/why-hillarycare-failedand-what-we-need-to-learn-from-that-failure/>.

⁷⁵ Ibid

⁷⁶ Natasha Singer. "Harry and Louise Return, With a New Message." *The New York Times*, July 16, 2009. <https://www.nytimes.com/2009/07/17/business/media/17adco.html>.

⁷⁷ "Timeline: History of Health Reform in the U.S." *The Kaiser Family Foundation*, May 2, 2013. <https://kaiserfamilyfoundation.files.wordpress.com/2011/03/5M-02-13-history-of-health-reform.pdf>.

⁷⁸ Billy Wynne. "May The Era Of Medicare's Doc Fix (1997-2015) Rest In Peace. Now What?" *Health Affairs*, April 15, 2015. <https://www.healthaffairs.org/doi/10.1377/hblog20150415.046932/full/>.

13 years.⁷⁹ By 2015, when the so-called “Doc-fix” legislation permanently repealed SGR, the formula would have caused a 21% cut in Medicare provider reimbursements.⁸⁰

The most recent successful expansion of health insurance coverage was the 2010 Affordable Care Act (ACA), President Barack Obama’s signature achievement. The first U.S. law which truly sought to achieve universal insurance coverage, the ACA expanded Medicaid enrollment, created subsidies to help those of modest incomes afford private health insurance, and established a wide range of consumer-centric standards and reforms.⁸¹ Consistent with previous opponents of universal coverage, Republican lawmakers warned that Obama’s plan was a slippery slope on the road to “socialized” medicine, but the bill passed nonetheless.⁸²

Passage of the ACA involved a series of dramatic events. In 2009, the Democrats had a majority in the House of Representatives and a 60-vote, filibuster-proof supermajority in the Senate. This should have enabled smooth passage of healthcare reform without any Republican votes, but the Senate supermajority proved fleeting. It lasted just five months, beginning with the delayed swearing in of Senator Al Franken (D-MN) in July and ending with Republican Scott Brown’s January victory in the election to replace Senator Ted Kennedy (D-MA) after his death. Democrats, then lacking a Senate supermajority, relied on parliamentary maneuvers including budget reconciliation to pass the

⁷⁹ Ibid

⁸⁰ “What was the Medicare ‘doc fix’ legislation?” *Medicare Resources*, February 24, 2018. <https://www.medicareresources.org/faqs/what-is-the-medicare-doc-fix-legislation/>.

⁸¹ Kimberly Amadeo. “Obama’s Health Care Reform Plan.” *The Balance*, March 21, 2019. <https://www.thebalance.com/obama-s-health-care-reform-plan-3305753>.

⁸² Ibid

transformational, yet imperfect ACA into law on a strictly party-line vote on March 21, 2010.⁸³

During the early days of the ACA debate, President Obama proposed a public insurance option, which could have both expanded coverage and cut costs more so than the version passed into law.⁸⁴ On paper, the Democrats had the votes to pass the ACA with a public option, but Senator Kent Conrad (D-NE), a moderate from Nebraska, argued strongly against the provision on the basis that it expanded government's role in healthcare to an unacceptable extent. Senator Joe Lieberman (I-CT) announced soon after that he would filibuster any legislation which included a public insurance option, effectively ending consideration of the provision.⁸⁵ Lieberman's decision was likely influenced by fact that insurance is the largest industry in his home state of Connecticut—in fact, the sector contributed significant sums of money to his campaigns.⁸⁶

In a stark break with tradition, the AMA actually supported passage of the ACA on the basis that expanding coverage would be good for patients.⁸⁷ This shift can be largely explained by examining the proportion of doctors represented by the organization. During the 1950s, 75% of practicing doctors were members; by 2016 this figure had dropped to just 25%.⁸⁸ Reflecting the generally increasing polarization of American society, a range

⁸³ Kimberly Amadeo. "Obama's Health Care Reform Plan." *The Balance*, March 21, 2019. <https://www.thebalance.com/obama-s-health-care-reform-plan-3305753>.

⁸⁴ Ibid

⁸⁵ Sydelle Moore. "Lieberman to Vote Against Public Option." *The Hill*, October 27, 2009. <https://thehill.com/homenews/senate/64981-senator-lieberman-not-backing-public-option>.

⁸⁶ Ibid

⁸⁷ Judith Graham. "'Like a slap in the face': Dissent roils the AMA, the nation's largest doctor's group." *Stat News*, December 22, 2016. <https://www.statnews.com/2016/12/22/american-medical-association-divisions/>.

⁸⁸ Ibid

of doctors' groups has sprung up across the political spectrum, from Doctors for America on the left to the Benjamin Rush Institute on the right.⁸⁹

Many additional organizations advocated for the ACA, including other provider groups such as the American Nursing Association and consumer groups including AARP and Families USA.⁹⁰ The pharmaceutical industry trade group, PhRMA, ended up supporting the ACA to head off any structural reforms (such as single payer) that could significantly disrupt the industry's business model.⁹¹ In fact, the same actors who played Harry and Louise in the 1990's reprised their roles in a new political advertisement—funded by PhARMA rather than the insurance industry—this time in support of healthcare reform.⁹² In comparison, America's Health Insurance Plans (AHIP), the health insurance industry trade group, pursued a two-track strategy regarding the ACA.⁹³ AHIP was a strong force at the negotiating table throughout the ACA debate, but at the same time was covertly spending millions of dollars in advertising to sink the bill.⁹⁴ Because the ACA required individuals to become customers of insurance companies, it's surprising that AHIP would have so vehemently opposed the bill. How could Dunkin' Donuts oppose a doughnut mandate? Well, according to Neera Tanden, a former adviser to President Obama, the

⁸⁹ Ibid

⁹⁰ "Complete List of Groups that Support this Health Care Bill." Office of U.S. Congressman Jim Cooper, March 23, 2010. <https://cooper.house.gov/media-center/press-releases/complete-list-of-groups-that-support-this-health-care-bill>.

⁹¹ Brett Norman and Sarah Karlin-Smith. "The one that got away: Obamacare and the drug industry." *Politico*, July 13, 2016. <https://www.politico.com/story/2016/07/obamacare-prescription-drugs-pharma-225444>.

⁹² Natasha Singer. "Harry and Louise Return, With a New Message." *The New York Times*, July 16, 2009. <https://www.nytimes.com/2009/07/17/business/media/17adco.html>.

⁹³ Rick Ungar. "Busted! Health Insurers Secretly Spent Huge To Defeat Health Care Reform While Pretending To Support Obamacare." *Forbes*, June 25, 2012. <https://www.forbes.com/sites/rickungar/2012/06/25/busted-health-insurers-secretly-spent-huge-to-defeat-health-care-reform-while-pretending-to-support-obamacare/#1b1508fe4248>.

⁹⁴ Ibid

ACA's requirement that insurers spend 80% of premium costs on care made the bill unacceptable to AHIP.⁹⁵

As originally passed, the ACA included several provisions that would never be fully implemented. For example, the CLASS Act was supposed to create a voluntary long-term care insurance program.⁹⁶ As designed, CLASS was entirely self-funded by premiums, without assistance from the general treasury. But if premiums were to be affordable to consumers, the revenue would have been insufficient to cover the costs of the program.⁹⁷ And due to the lack of an individual mandate, CLASS would likely have suffered from adverse selection, raising costs and making the program unsustainable.⁹⁸ Perhaps, in a more agreeable political environment, CLASS could have been saved. But the provision was never implemented and later was repealed by Congress in 2013.⁹⁹

Another ACA provision, the Cadillac Tax, was designed to limit the incentives for employers to offer overly-generous and costly health insurance plans (as mentioned in the *Statement of the Problem* section). This provision—delayed from taking effect to this day by Congress—would levy a 40% tax on employer health benefits above a certain threshold.¹⁰⁰ Critics argue the tax is a blunt and inefficient way to approach this problem, particularly since the threshold is not pegged to inflation and would therefore eventually

⁹⁵ Rick Ungar. "Busted! Health Insurers Secretly Spent Huge To Defeat Health Care Reform While Pretending To Support Obamacare." *Forbes*, June 25, 2012. <https://www.forbes.com/sites/rickungar/2012/06/25/busted-health-insurers-secretly-spent-huge-to-defeat-health-care-reform-while-pretending-to-support-obamacare/#1b1508fe4248>.

⁹⁶ Harold Pollack. "ACA's CLASS Act Pushed Over the Fiscal Cliff." *MedicareResources.Org*, January 2, 2013. <https://www.medicareresources.org/blog/2013/01/02/acas-class-act-pushed-over-the-fiscal-cliff/>.

⁹⁷ Ibid

⁹⁸ Ibid

⁹⁹ Ibid

¹⁰⁰ Auxier, et al. "What is the Cadillac Tax?" *Tax Policy Center*, 2018. <https://www.taxpolicycenter.org/briefing-book/what-cadillac-tax>.

apply to all employer-sponsored plans.¹⁰¹ Another failed ACA provision, the Independent Payment Advisory Board (IPAB) was an attempt to control Medicare spending while enhancing quality of care.¹⁰² During the ACA debate, IPAB was the target of the misleading “death panel” label, a characterization it was unable to recover from.¹⁰³ The board was never fully implemented and eventually was repealed by Congress in 2017.¹⁰⁴

Uninsured Rate Trends

The U.S. first began to record the uninsured rate soon after the passage of Medicare and Medicaid, likely to measure the effectiveness of these new programs.¹⁰⁵ In 1972, the Centers for Disease Control found that 16.7% of those under age 65 were not covered by any type of insurance for at least part of the year. By 1978, this figure had fallen to 12%, driven by strong economic growth and the implementation of Medicaid.¹⁰⁶ However, the recession of 1980-1981 blunted these gains and over the next decade the labor market shifted from predominantly high-benefit manufacturing jobs to lower-benefit service sector jobs.¹⁰⁷ As a result, by 1991 far fewer households were covered by employer-sponsored plans and the uninsured rate had risen above 16%, nearly as high as prior to the implementation of Medicare and Medicaid.¹⁰⁸

¹⁰¹ Ibid

¹⁰² Juliette Cubanski and Tricia Neuman. "FAQs: What's the Latest on IPAB?" *The Kaiser Family Foundation*, November 3, 2017. <https://www.kff.org/medicare/issue-brief/faqs-whats-the-latest-on-ipab/>.

¹⁰³ Ibid

¹⁰⁴ Ibid

¹⁰⁵ "Trends in Health Care Coverage and Insurance for 1968-2011." *Centers for Disease Control and Prevention, U.S. Department of Health and Human Services*, November 6, 2015. https://www.cdc.gov/nchs/health_policy/trends_hc_1968_2011.htm.

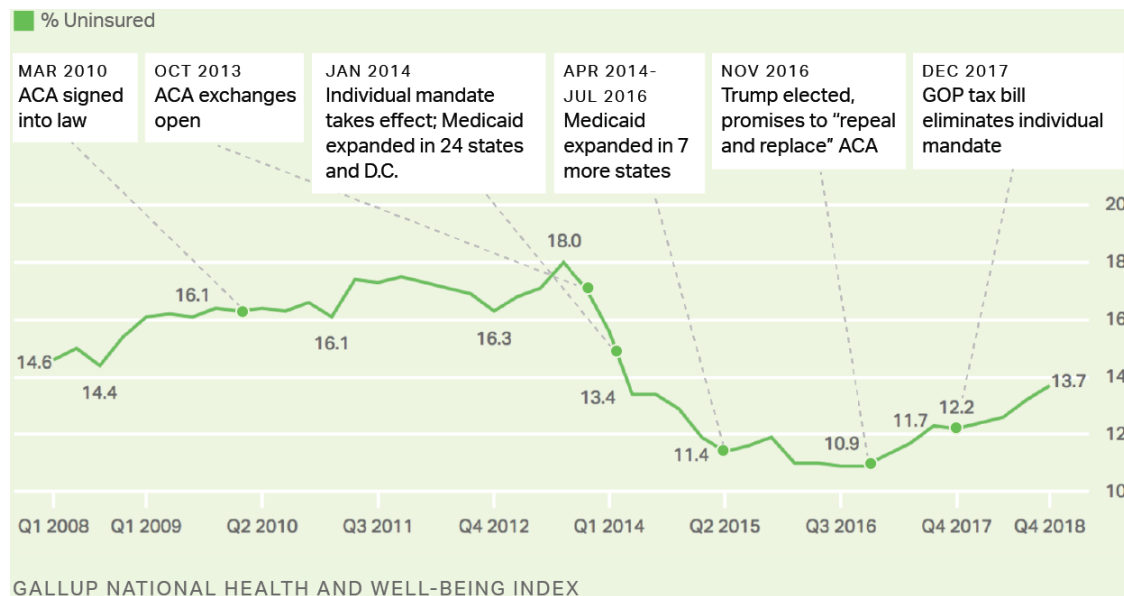
¹⁰⁶ Ibid

¹⁰⁷ Levit, et al. "Americans' Health Insurance Coverage, 1980-91." *Health Care Financing Review*, 1992. <https://www.ncbi.nlm.nih.gov/pubmed/10124438>.

¹⁰⁸ Ibid

The uninsured rate generally hung around 16-17% from the 1989 through 2008, until the massive job losses of the Great Recession drove the rate up to a modern record of 18.2% by 2010.¹⁰⁹ As the economy improved and the Affordable Care Act was implemented, the uninsured rate dropped dramatically. By the end of the ACA's first open enrollment period in March 2014, a remarkable 12.8 million people had gained coverage through the Medicaid expansions or the new federal and state marketplaces—representing a 4-percentage point drop in the uninsured rate.¹¹⁰ According to a Commonwealth Fund study, three-quarters of the drop could be attributed to the ACA, while the remaining one-quarter was caused by faster economic growth.¹¹¹

Figure 3: Percentage of U.S. Adults Without Health Insurance, 2008-2018



¹⁰⁹ "Uninsured Rate among the Nonelderly Population, 1972-2018." *The Kaiser Family Foundation*, Aug 28, 2018. <https://www.kff.org/uninsured/slide/uninsured-rate-among-the-nonelderly-population-1972-2018/>.

¹¹⁰ Sherry Glied, Stephanie Ma, and Sarah Verbofsky. "How Much of a Factor is the Affordable Care Act in the Declining Uninsured Rate?" *The Commonwealth Fund*, December 2016. https://www.commonwealthfund.org/sites/default/files/documents/_media_files_publications_issue_brief_2016_dec_1920_glied_aca_and_uninsured_rate_rb_v3.pdf.

¹¹¹ Ibid

¹¹² Dan Witters. "U.S. Uninsured Rate Rises to Four-Year High." *Gallup*, January 23, 2019. <https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx>.

As more states expanded their Medicaid programs and strong economic growth persisted, the uninsured rate continued to drop through 2016, to a low of 10.9% that fall. However, as depicted above in Figure 3, this trend began to reverse after President Trump was inaugurated in January 2017. The new administration tightened eligibility standards for Medicaid, cut premium and cost-sharing subsidies, and decreased funding for the promotion of ACA open enrollment.¹¹³

In addition to Congress' repeal of the individual mandate, these policy shifts have directly caused 1.4 million Americans to lose their coverage, driving the uninsured rate up to 13.7% by the beginning of 2019 despite the continued economic expansion.^{114,115} In addition to these efforts, Congressional Republicans repeatedly attempted to "repeal and replace" the Affordable Care Act.¹¹⁶ These GOP alternatives failed because they would have caused millions to lose their coverage, a stance which proved deeply unpopular among voters.¹¹⁷ As a result, the law has been largely preserved, to be improved or supplanted by future policy makers.

Root Causes of Uninsurance

Cost is the primary root cause of uninsurance, particularly because plans that are not subsidized by employers or the government are unaffordable for many Americans. In

¹¹³ Allison Inzerro. "CMS Cuts Budget for ACA Marketing to \$10 Million for 2019 Plan Year." *American Journal of Managed Care*, July 11, 2018. <https://www.ajmc.com/newsroom/cms-cuts-budget-for-aca-marketing-to-10-million-for-2019-plan-year>.

¹¹⁴ "Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018." *The Congressional Budget Office*, April 2019. <https://www.cbo.gov/system/files/2019-04/55094-CoverageUnder65.pdf>.

¹¹⁵ Dan Witters. "U.S. Uninsured Rate Rises to Four-Year High." *Gallup*, January 23, 2019. <https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx>.

¹¹⁶ Sean Sullivan. "Republicans Abandon the Fight to Repeal and Replace Obama's Health Care Law." *The Washington Post*, November 7, 2018. https://www.washingtonpost.com/powerpost/republicans-abandon-the-fight-to-repeal-and-replace-obamas-health-care-law/2018/11/07/157d052c-e2d8-11e8-ab2c-b31dcd53ca6b_story.html.

¹¹⁷ Ibid

fact, nearly half of the uninsured cited the high cost of insurance as a significant barrier to obtaining coverage.¹¹⁸

Another important cause of uninsurance is the fragmented patchwork of public and private plans and programs. Health coverage in the U.S. is highly dependent on specific life statuses that tend to change suddenly, often causing people to lose their current plan. A Kaiser Family Foundation survey found that 23% of the uninsured in 2017 no longer had coverage because a family member lost or changed jobs.¹¹⁹ Also, 11% of the uninsured reported they lost coverage due to divorce, the death of a spouse or parent, aging out of their coverage (young people lose CHIP coverage at 19 and can no longer be on their parents' plans at 26), or leaving college (which had provided coverage).^{120,121,122} Another 11% became uninsured after losing Medicaid coverage because their incomes rose above the eligibility threshold or because their pregnancy-related Medicaid coverage ended (expires 60 days after giving birth).^{123,124}

The state-level debates over expanding Medicaid—as the ACA intended—are highly relevant to the goal of expanding health coverage. But in truth, the “expansion gap,” or the population that earns too much for Medicaid eligibility and too little to qualify for

¹¹⁸ "Estimates of Eligibility for ACA Coverage among the Uninsured in 2016." *The Kaiser Family Foundation*, 2018. <https://www.kff.org/uninsured/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/>.

¹¹⁹ *Ibid*

¹²⁰ *Ibid*

¹²¹ Dee Mahan. "The Children's Health Insurance Program (CHIP)." *Families USA*, September 2017.

<https://familiesusa.org/product/children-health-insurance-program-chip>.

¹²² "Young Adults and the Affordable Care Act." *Employee Benefits Security Administration, U.S. Department of Labor*. <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/young-adult-and-aca>.

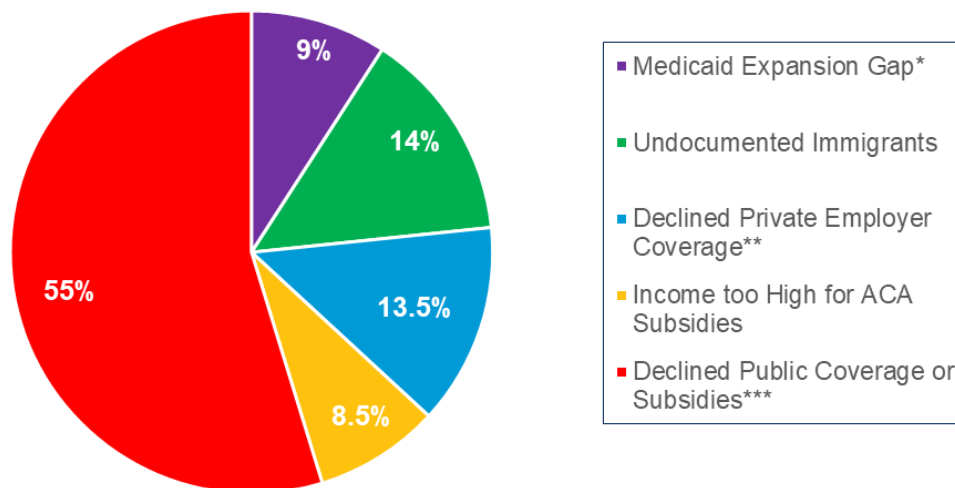
¹²³ "Key Facts about the Uninsured Population." *The Kaiser Family Foundation*, December 7, 2018.

<https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

¹²⁴ Amy Chen. "Q&A on Pregnant Women's Coverage Under Medicaid and the ACA." *National Health Law Program*, September 5, 2018. <https://healthlaw.org/resource/qa-on-pregnant-womens-coverage-under-medicaid-and-the-aca/>.

ACA marketplace subsidies, comprises just 9% of the uninsured, or 2.5 million people.¹²⁵ As depicted in Figure 4 below, another 2.3 million uninsured people, or 8.5% of the total, earn too much to qualify for ACA subsidies but would not be eligible for Medicaid even in expansion states.¹²⁶ The largest group of Americans without health coverage—55% of the uninsured population or 15 million people—were eligible for but declined Medicaid coverage or ACA marketplace subsidies.¹²⁷

*Figure 4: Breakdown of the 27.4 Million Uninsured Americans, 2017*¹²⁸



Figures are in Millions

*Due to states which did not expand Medicaid.

**Ineligible for ACA plans or subsidies.

***Including Medicaid, ACA subsidies, and others.

Source of Data: *The Kaiser Family Foundation*¹²⁹

Interestingly, 13.5% of the uninsured, or 3.7 million people had an offer of ESI from their employer but declined it.¹³⁰ Surveys have shown that 90% of those who declined an offer

¹²⁵ "Key Facts about the Uninsured Population." *The Kaiser Family Foundation*, December 7, 2018. <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

¹²⁶ Ibid

¹²⁷ Ibid

¹²⁸ "Estimates of Eligibility for ACA Coverage among the Uninsured in 2016." *The Kaiser Family Foundation*, 2018. <https://www.kff.org/uninsured/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/>.

¹²⁹ Ibid

of employer coverage (and are not covered by another source) did so because of cost.¹³¹ Unfortunately, workers who decline ESI are by law not eligible for ACA marketplace subsidies, though they could benefit from such assistance. The final category consists of undocumented immigrants, who make up 14% of the uninsured, or 3.9 million people.¹³² Undocumented immigrants are not eligible for coverage under the ACA marketplaces or Medicaid, though legal immigrants who meet certain income and residency-duration requirements may qualify for either program.

The Stakeholder Landscape

Any serious healthcare reform proposal must consider the perspectives of the numerous different stakeholders that would be affected. These stakeholders can be broadly categorized into four groups: payers, providers, producers, and consumers.

The payers include private insurance companies, employers, and the federal and state governments, which collectively fund all U.S. healthcare spending. Health consumers also fund a portion of national health expenditures, but they have been placed in a separate category because their interests generally differ from the rest of the payers.

Insurance companies may be more likely to support individual mandates because such laws require uninsured people to buy their products.¹³³ But to protect its revenue base and its very existence, the insurance industry is unlikely to support any proposal which shifts

¹³⁰ "Key Facts about the Uninsured Population." *The Kaiser Family Foundation*, December 7, 2018. <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

¹³¹ Ibid

¹³² Ibid

¹³³ Christine Eibner and Sarah Nowak. "The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors." *The Commonwealth Fund*, July 11, 2018. <https://www.commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty-behavioral-factors>.

the country away from private health insurance (e.g., a public option) or eliminates private coverage outright.

Federal and state government leaders might share the goal of having a healthy, insured populace, but their more immediate concern is likely to bring health spending down to a sustainable rate. This would take pressure off federal and state budgets, allowing policy makers to lower taxes or shift spending to other priorities. Employers play a much smaller role, since they largely pass healthcare cost on to their workers in the form of lower wages.¹³⁴ Smaller employers (with fewer than 50 employees) were less likely to offer health insurance before the ACA mandate and generally have more difficulty insulating employees from rising health costs.¹³⁵ All employers might want to preserve the ESI tax exclusion and avoid uncertainty about how different health reform proposals would affect their employees.

The providers are comprised of the hospitals and health professionals (including doctors, nurse practitioners and RNs, etc.) that actually deliver the care to consumers. The members of this category are decidedly not united in their policy preferences. Doctors historically have opposed universal insurance schemes because of the perception that a highly-regulated, government-run system would shift power away from them.¹³⁶ For example, Medicare and Medicaid set provider reimbursement rates much lower compared

¹³⁴ Tom Murphy. "Survey: Companies continue to pass health costs to workers." *The Associated Press*, October 3, 2018. <https://apnews.com/58b40c55b367490fa859a58a3a505903>.

¹³⁵ "Employer Mandate." *U.S. Chamber of Commerce*. <https://www.uschamber.com/health-reform/employer-mandate>.

¹³⁶ "National Health Insurance—A Brief History of Reform Efforts in the U.S." *The Kaiser Family Foundation*, March 2009. Published online January 2013. <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7871.pdf>.

to private payers, leading to lower salaries for doctors and nurses and lower revenues for hospitals.¹³⁷

However, health providers in areas with high concentrations of Medicaid-eligible patients may perceive debates around health reform differently. Medicaid reimbursement rates are even lower than Medicare rates, and so these providers could potentially benefit from uniform rate setting.¹³⁸ Registered nurses, advanced-practice nurses, and other health providers deliver quality care at a fraction of the price of doctors, who would be better reserved for more complex cases.¹³⁹ Therefore, decreased overall reimbursement rates would affect nurses of all types less severely. And as their profession gains credibility and greater “scope of practice” to enter more areas of care, advanced-practice registered nurses may be more receptive to disrupting the doctor-friendly status quo. Conversely, doctors in specialist roles receive much higher reimbursement rates than primary care doctors, and therefore any attempt to lower rates would disproportionately affect specialists.¹⁴⁰

Education costs are high for all providers, but this is the case for doctors in particular.

The cost of medical school rose by twice the rate of inflation from 1998 to 2008.¹⁴¹ As a result, doctors are likely to argue that reimbursement rates and therefore salaries must be

¹³⁷ Tara Bannow. “Low reimbursement, high expenses contribute to poor 2018 not-for-profit healthcare outlook.” *Modern Healthcare*, December 4, 2017. <https://www.modernhealthcare.com/article/20171204/NEWS/171209962/low-reimbursement-high-expenses-contribute-to-poor-2018-not-for-profit-healthcare-outlook>.

¹³⁸ “Medicaid-to-Medicare Fee Index.” *The Kaiser Family Foundation*, 2017. <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/>.

¹³⁹ Jennifer Bresnick. “How NPs, PAs Add Value to Population Health Management Teams.” *Health IT Analytics*, April 11, 2018. <https://healthitanalytics.com/news/how-nps-pas-add-value-to-population-health-management-teams>.

¹⁴⁰ Bruce Japsen. “Doctor Pay Tops \$257K For Primary Care, \$425K For Specialists.” *Forbes*, May 21, 2018. <https://www.forbes.com/sites/brucejapsen/2018/05/21/primary-care-doctor-pay-tops-257000-amid-shift-to-value/#5376bc9c97bf>.

¹⁴¹ Caroline Claire Elbaum. “The Price We Pay: How the Cost of Medical School Contributes to US Healthcare Disparities and Spending.” *Tufts University*, April 9, 2017. <https://sites.tufts.edu/cmph357/2017/04/09/the-price-we-pay-how-the-cost-of-medical-school-contributes-to-us-healthcare-disparities-and-spending/>.

high in order to justify their entry into the profession. Another area of concern for providers is medical malpractice. The U.S. has much higher per capita tort damage awards compared to similarly wealthy countries.¹⁴² In fact, fear of malpractice lawsuits has been shown to increase “defensive medicine,” or potentially unneeded treatments that drive up health costs.¹⁴³ However, these damages are not unjustified, given a Johns Hopkins University study which found that medical errors are the “third leading cause of death in the U.S.” And so, while patients need avenues for redress if they are harmed by a health provider, reforms should consider the provider incentives created by the current tort system.

The producers are the companies which develop prescription and over-the-counter drugs as well as medical devices and diagnostic tests.¹⁴⁴ Pharmaceutical companies enjoy the status quo in the U.S. where comparatively high drug costs drive strong revenue growth and fund the development of new drugs used across the world.¹⁴⁵ Americans spend twice as much on pharmaceuticals per person compared with European countries and medical devices have been found to be six times more expensive than in Europe.¹⁴⁶ The producers in general tend to pass the costs of drugs along to payers and consumers rather than

¹⁴² “International Comparisons of Litigation Costs.” *Institute for Legal Reform, U.S. Chamber of Commerce*, June 2013. https://www.instituteforlegalreform.com/uploads/sites/1/ILR_NERA_Study_International_Liability_Costs-update.pdf.

¹⁴³ M Sonal Sekhar and N Vyas. “Defensive Medicine: A Bane to Healthcare.” *Annals of Medical and Health Sciences Research*, April 2013. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3728884/>.

¹⁴⁴ Chuck Dinerstein. “An Overlooked Health Care Cost - The Medical Device Market.” *American Council on Science and Health*, October 3, 2018. <https://www.acsh.org/news/2018/10/03/overlooked-health-care-cost-medical-device-market-13468>.

¹⁴⁵ Dana Goldman and Darius Lakdawalla. “The Global Burden of Medical Innovation.” *The Brookings Institution*, January 30, 2018. <https://www.brookings.edu/research/the-global-burden-of-medical-innovation/>.

¹⁴⁶ Martin Wenzl and Elias Mossialos. “Prices For Cardiac Implant Devices May Be Up To Six Times Higher In The US Than In Some European Countries.” *Health Affairs*, October 2018. <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.1367>.

attempting to lower overall prices.¹⁴⁷ These companies also thrive in an environment of low pricing transparency and high variability, making it difficult for consumers and other payers to know if they are getting a good deal.¹⁴⁸ Drug makers prefer the current state where Medicare is not allowed to negotiate drug prices and other payers tend not to do so either.¹⁴⁹ Another member of this group is the Pharmacy Benefit Managers, known as PBMs, which act as middle-men between providers and pharmaceutical companies. PBMs add costs to the system without providing value to either consumers or payers.¹⁵⁰ Finally, the consumers of healthcare are the individuals and families who become patients when they interact with the healthcare system. Health consumers could be affected in vastly divergent ways by different universal coverage proposals. For example, Americans over age 65 receive their health insurance mostly from Medicare, a public program they might not want altered.¹⁵¹ The nearly half of Americans who receive Employer-Sponsored Insurance might prefer that their plans are not disrupted, even if they aren't entirely happy with their existing coverage.¹⁵² Also, wealthier, younger, and healthier people might be opposed to the idea of "social insurance" wherein these groups subsidize coverage for lower-income, older, and sicker people. And all consumers prefer

¹⁴⁷ Charles Ornstein. "A New Way Insurers are Shifting Costs to the Sick." *ProPublica*, September 17, 2014.

<https://www.propublica.org/article/a-new-way-insurers-are-shifting-costs-to-the-sick>.

¹⁴⁸ Chuck Dinerstein. "An Overlooked Health Care Cost - The Medical Device Market." American Council on Science and Health, October 3, 2018. <https://www.acsh.org/news/2018/10/03/overlooked-health-care-cost-medical-device-market-13468>.

¹⁴⁹ Richard Knox. "Why Are U.S. Health Costs The World's Highest? Study Affirms 'It's The Prices, Stupid!'" *WBUR Public Radio*, March 13, 2018. <https://www.wbur.org/commonhealth/2018/03/13/us-health-costs-high-jha>.

¹⁵⁰ Olga Khazan. "Invisible Middlemen Are Slowing Down American Health Care." *The Atlantic*, April 9, 2019. <https://www.theatlantic.com/health/archive/2019/04/pbms-health-care-drug-delays-prices/586711/>.

¹⁵¹ Ashley Kirzinger, Cailey Muñana, and Mollyann Brodie. "The Public On Next Steps For The ACA And Proposals To Expand Coverage." *The Kaiser Family Foundation*, January 23, 2019. <https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2019/>.

¹⁵² Joseph Antos. "Capping the Tax Exclusion Will Not Destroy Employer Health Insurance." *Forbes*, April 26, 2014. <https://www.forbes.com/sites/realspin/2016/04/26/capping-the-tax-exclusion-will-not-destroy-employer-health-insurance/>.

wide networks of providers and generous availability of prescription drugs and procedures.¹⁵³

Consumers of healthcare are, of course, also voters whose opinions are of great importance to policymakers. Public opinion of the U.S. health system has been remarkably, consistently negative since Gallup started asking about it in 1994.¹⁵⁴ In 2019, Gallup found that 70% of Americans believe the U.S. healthcare system is "in a state of crisis" or having "major problems," though his figure has typically ranged from 65-73% of respondents since 1994.¹⁵⁵ Gallup's polling also suggests that public opinion on healthcare has become highly partisan. As the debate raged over the Affordable Care Act's passage and implementation, Democrats became far less likely to rate the U.S. healthcare system negatively, while Republicans became far more likely to do so.¹⁵⁶ After President Donald Trump was elected in 2016 and began a legislative and regulatory campaign to alter the ACA, these trends flipped, with Republicans becoming more favorable of the healthcare system and Democrats less so. These insights are important to consider if bipartisan buy-in is to be built for any future reforms.

Who Pays for Healthcare?

The most recent National Health Expenditures (NHE) data paints a picture of the different payers which collectively spent \$3.49 trillion on healthcare in 2017.¹⁵⁷ Overall,

¹⁵³ "Ask the AHIP Experts: Why Provider Networks are Important." America's Health Insurance Plans, December 27, 2018. <https://www.ahip.org/ask-the-ahip-experts-why-provider-networks-are-important/>.

¹⁵⁴ Justin McCarthy. "Seven in 10 Maintain Negative View of U.S. Healthcare System." *Gallup*, January 14, 2019. <https://news.gallup.com/poll/245873/seven-maintain-negative-view-healthcare-system.aspx>.

¹⁵⁵ Ibid

¹⁵⁶ Ibid

¹⁵⁷ "NHE Tables." *Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, 2019. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip>.

public spending comprised 45% of NHE and private spending 55%.¹⁵⁸ Medicare cost \$583 billion that year, making up 16.7% of the total (not including beneficiary premiums).¹⁵⁹ Medicaid cost \$582 billion (61% federal, 39% state) representing 17% of the total.¹⁶⁰ Private businesses spent \$935.5 billion or 26.7% of NHE (mostly consisting of payroll tax contributions and premiums) while household spending totaled \$978.6 billion, or 28% of the total (consisting of payroll taxes, premiums, and out-of-pocket costs).¹⁶¹ And the remaining \$398 billion or 11.4% of the total included other public healthcare spending at the federal, state, and local levels.¹⁶² However, these figures do not include federal spending that subsidizes private health coverage, including ACA subsidies, which totaled \$45 billion in 2017, and the Employer-Sponsored Insurance tax exclusion, which cost \$260 billion that year.¹⁶³ These public health insurance programs are expensive for the federal government not because of inherent flaws in their design, but because healthcare in the U.S. is expensive.¹⁶⁴ In fact, as asserted in the *Action-Forcing Event* section of this memo, public healthcare spending is growing much slower than private spending.¹⁶⁵

¹⁵⁸ Ibid

¹⁵⁹ Ibid

¹⁶⁰ Ibid

¹⁶¹ Ibid

¹⁶² Ibid

¹⁶³ Ibid

¹⁶⁴ Bradley Sawyer and Cynthia Cox. "How does Health Spending in the U.S. Compare to Other Countries?" *Peterson-Kaiser Health System Tracker*, December 7, 2018. <https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/>.

¹⁶⁵ John Holahan and Stacey McMorrow. "Slow Growth in Medicare and Medicaid Spending Per Enrollee has Implications for Policy Debates." *Robert Wood Johnson Foundation*, February 11, 2019. <https://www.rwjf.org/en/library/research/2019/02/slow-growth-in-medicare-and-medicaid-spending-per-enrollee.html>.

Where Does All the Money Go?

As mentioned earlier, \$3.49 trillion was spent on healthcare in the U.S. in 2017. Overall, 64% of this spending went towards clinical health professionals and hospitals, as depicted in Table 1, below. Though insurance companies are a payer, insurance overhead represented 6.6% of overall healthcare spending.¹⁶⁶ Federal and state governments, though also payers, directly funded 3.8% of overall spending in the form of administrative costs and public health activities.¹⁶⁷ Prescription drugs comprised 9.5% of total health expenditures, while medical equipment and over-the-counter drugs made up 3.4%.¹⁶⁸ Finally, long-term care costs comprised 7.5% of the total.¹⁶⁹

Table 1: National Health Expenditures by Type of Expenditure, 2017

Type of Expenditure	Amount in Billions	Percent
Total	\$3,492.1	100%
Hospital Care	1,142.6	32.7%
Health Professional Clinical Services	1,103.1	31.6%
Prescription Drugs	333.4	9.5%
Long-term Care Across All Settings	263.3	7.5%
Health Insurance Administrative Costs	229.5	6.6%
Investment in Research and Infrastructure	167.6	4.8%
Medical Equipment and Products	118.5	3.4%
Government Public Health Activities	88.9	2.5%
Government Administration	45.0	1.3%

*SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.*¹⁷⁰

¹⁶⁶ "NHE Tables." *Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, 2019. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip>.

¹⁶⁷ Ibid

¹⁶⁸ Ibid

¹⁶⁹ Ibid

¹⁷⁰ Ibid

Root Causes of High Healthcare Costs

Though a multitude of structural factors contribute to U.S. health costs—the aging of the population, high cost of medical school, malpractice costs, and administrative overhead—recent research suggests these are insufficient to explain the vastly higher costs of care when compared to the Canadian and European systems.¹⁷¹ The late economist Uwe Reinhardt points out in his article, *It's the Prices, Stupid*, that higher utilization is also not the cause of higher healthcare prices in the U.S., given that Americans actually use less care than Europeans per capita.¹⁷² Reinhardt argues that “the difference in healthcare spending (compared to European countries) is caused mostly by higher prices for health care goods and services in the United States.”¹⁷³ Ultimately, healthcare producers and providers can charge such high prices largely because no payer can compete at the negotiating table with the monopolistic market power of large and increasingly consolidating hospital and pharmaceutical companies.¹⁷⁴ As a result, employers and households don't have the market share to negotiate with healthcare companies, while federal programs generally do have more of a capability to influence prices.¹⁷⁵ The largest government payer, Medicare, does set prices for most health services—leading to lower costs for the program—but is not allowed to negotiate on pharmaceutical prices.¹⁷⁶ Unless prices for all healthcare products and services are

¹⁷¹ Richard Knox. “Why Are U.S. Health Costs The World's Highest? Study Affirms 'It's The Prices, Stupid'.” *WBUR Public Radio*, March 13, 2018. <https://www.wbur.org/commonhealth/2018/03/13/us-health-costs-high-jha>.

¹⁷² Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan. “It's the Prices, Stupid: Why the United States Is So Different from Other Countries.” *Health Affairs*, 2003.

<https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.22.3.89>.

¹⁷³ Ibid

¹⁷⁴ Christopher Jacobs. “Why Hospital Monopolies Are What's Wrong With American Health Care.” *The Federalist*, September 28, 2018. <https://thefederalist.com/2018/09/28/hospital-monopolies-whats-wrong-american-health-care/>.

¹⁷⁵ John Wasik. “Why Medicare Can't Get The Lowest Drug Prices.” *Forbes*, August 10, 2018.

<https://www.forbes.com/sites/johnwasik/2018/08/10/why-medicare-cant-get-the-lowest-drug-prices/#7ac1d43a302b>

¹⁷⁶ Ibid

negotiated under a unified framework, providers and producers will be able to charge different prices to different payers and health system costs will remain uncontrolled.

Comparison of Health System Types

Currently, the U.S. has much worse health outcomes compared to similarly wealthy countries despite spending double per person on healthcare.¹⁷⁷ Furthermore, all similarly wealthy countries have universal or near-universal healthcare coverage, compared to the fragmented U.S. insurance system which currently leaves out 13.7% of the population.¹⁷⁸ There is surprising diversity in how other wealthy countries structure their health systems: Canada and the United Kingdom have true single-payer systems where the federal government pays for all essential healthcare costs through taxes.¹⁷⁹ On the other hand, Switzerland has a private pay model paired with subsidies for low-income people, similar to the ACA, which translates into higher spending but potentially better care.¹⁸⁰ Other countries use multiple-payer frameworks, where health insurance is sold by several competing entities. For example, in Germany 130 non-governmental non-profit organizations sell comprehensive, mandatory health insurance.¹⁸¹

It can be easier to control costs when there is only one primary payer of healthcare, but the competition inherent in multiple-payer systems may lead to more innovation and shorter wait times in exchange for some inefficiency. Finally, countries such as France

¹⁷⁷ "Mortality Amenable to Health Care." *The Commonwealth Fund*, 2017.

https://international.commonwealthfund.org/stats/mortality_amendable/.

¹⁷⁸ Kimberly Amadeo. "Why America is the Only Rich Country without Universal Health Care." *The Balance*, March 12, 2019. <https://www.thebalance.com/universal-health-care-4156211>.

¹⁷⁹ "Mortality Amenable to Health Care." *The Commonwealth Fund*, 2017.

https://international.commonwealthfund.org/stats/mortality_amendable/.

¹⁸⁰ Kimberly Amadeo. "Why America is the Only Rich Country without Universal Health Care." *The Balance*, March 12, 2019. <https://www.thebalance.com/universal-health-care-4156211>.

¹⁸¹ Ibid

have two-tier systems, where the government pays for basic healthcare services and private, for-profit companies offer better, faster, or additional options for those who can afford them.¹⁸² These different approaches can be combined in interesting ways: for example a multiple-payer system can add a two-tier element by allowing competition between public, private for-profit, and private non-profit organizations.

Table 2: Comparison of Selected Countries' Healthcare Systems and Outcomes

Country	Payer Type	Health Spending % of GDP ¹⁸³	Health Spending Per Capita ¹⁸⁴	% Wait 4+ Weeks for Care ¹⁸⁵	Uninsured Rate ^{186,187}	Amenable Deaths Per 100k People ¹⁸⁸
United States	Private*	17.9%	\$10,348	4.9%	13.7%	112
Comparably Wealthy Countries	N/A	9.1%	\$5,198	N/A	0.1%	70
United Kingdom	Single	9.6%	\$4,192	29.9%	0.0%	85
Canada	Single	10.4%	\$4,753	56.3%	0.0%	78
Germany	Multiple	11.3%	\$5,551	11.9%	0.0%	83
France	Two-Tier	11.5%	\$4,600	49.3%	0.1%	61
Switzerland	Private**	12.3%	\$7,919	20.2%	0.0%	55

NOTE: Data are most recent available, varying from 2016 to 2019.

*Public payers cover certain populations, including people over 65, with low-incomes, and veterans.

**Lower-income people receive public subsidies to purchase private insurance.

¹⁸² Ibid

¹⁸³ "Health Spending - OECD Data." *Organisation for Economic Co-Operation and Development*, 2017. <http://data.oecd.org/healthres/health-spending.htm>.

¹⁸⁴ Rabah Kamal and Cynthia Cox. "How do Healthcare Prices and use in the U.S. Compare to Other Countries?" *Peterson-Kaiser Health System Tracker*, May 8, 2018. <https://www.healthsystemtracker.org/chart-collection/how-do-healthcare-prices-and-use-in-the-u-s-compare-to-other-countries/>.

¹⁸⁵ Kimberly Amadeo. "Why America is the Only Rich Country without Universal Health Care." *The Balance*, March 12, 2019. <https://www.thebalance.com/universal-health-care-4156211>.

¹⁸⁶ Dan Witters. "U.S. Uninsured Rate Rises to Four-Year High." *Gallup*, January 23, 2019. <https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx>.

¹⁸⁷ Rabah Kamal. "The U.S. has the Lowest Insured Rate of all Comparable Countries." *Peterson-Kaiser Health System Tracker*. April 21, 2017. <https://www.healthsystemtracker.org/chart/u-s-lowest-insured-rate-comparable-countries/>.

¹⁸⁸ "Mortality Amenable to Health Care." *The Commonwealth Fund*, 2017. https://international.commonwealthfund.org/stats/mortality_amendable/.

Comparative assessments of health outcomes and the patient experience across different system types can be a helpful guide for policy makers. However, in comparing the U.S. healthcare system with similarly wealthy countries, the social determinants of health should be considered. As the Physicians Foundation notes, “U.S. determinants, such as poverty, poor housing, job and income status and socioeconomic characteristics (such as education) are relevant in every respect” of healthcare outcomes.¹⁸⁹ However, the amenable deaths metric helps control for social determinants by focusing on the performance of the system itself. This statistic measures the number of people who die due to sub-standard care, regardless of how sick the patients were prior to receiving care. As depicted in Table 2 above, the U.S. had 60% more amenable deaths than the average similarly wealthy country.¹⁹⁰ A range of healthcare system types appear to be more effective at avoiding deaths from treatable diseases than the U.S. system.

However, a benefit of the U.S. system—something American opponents of universal healthcare have focused on—is shorter wait times for care compared with every other wealthy country. While fewer than 5% of American patients have waited 4-plus weeks for any type of care, around 50% of French and Canadian patients reported waiting 4-plus weeks for care. Other benefits of the U.S. healthcare system include excellent but expensive care in complex cases and the highest rates of pharmaceutical development investment in the world.^{191,192}

¹⁸⁹ Gary Price and Tim Norbeck. "U.S. Health Outcomes Compared to Other Countries are Misleading." *Forbes*, April 9, 2018. <https://www.forbes.com/sites/physiciansfoundation/2018/04/09/u-s-health-outcomes-compared-to-other-countries-are-misleading/>.

¹⁹⁰ "Mortality Amenable to Health Care." *The Commonwealth Fund*, 2017. https://international.commonwealthfund.org/stats/mortality_amenable/.

¹⁹¹ Aaron E. Carroll and Austin Frakt. "The Best Health Care System in the World: Which One Would You Pick?" *The New York Times*, September 18, 2017. <https://www.nytimes.com/interactive/2017/09/18/upshot/best-health-care-system-country-bracket.html>.

Description of Policy Proposal

Policy Goals

The primary goal of this proposal is achieving universal health insurance coverage, defined as 100% of Americans covered by an affordable, adequate public or private health plan at all times. The secondary goal is constraining healthcare spending growth to a sustainable rate, defined as no more than 1.9% annually. This level is needed to keep the annual percentage of GDP spent on healthcare in 2018—17.4%—the same in 2035.¹⁹³

Policy Proposal Summary

This proposal attempts to achieve the goal of universal coverage by consolidating and expanding existing public health insurance programs, largely transitioning away from private employer-sponsored plans, and addressing the rising long-term care needs of older people. The secondary goal of containing healthcare cost growth is addressed by a new provider and hospital reimbursement system that sets healthcare prices through a multi-stakeholder process. The authorization tool used by this proposal is Congressional legislation to modify the Social Security Act. A change in the law is needed, rather than an executive order, because this proposal alters existing programs created by law and requires additional tax increases.

Coverage Expansion Description

The coverage expansion framework proposed in this memo is a unique creation inspired by former Rep. Pete Stark's (D-CA) AmeriCare plan, borrowing elements from the

¹⁹² Dana Goldman and Darius Lakdawalla. "The Global Burden of Medical Innovation." *The Brookings Institution*, January 30, 2018. <https://www.brookings.edu/research/the-global-burden-of-medical-innovation/>.

¹⁹³ Judith Lave, Paul Hughes-Cromwick, and Thomas Getzen. "Sustainable Health Spending and the U.S. Federal Budget." *Altarum Institute*, November 13, 2012. https://altarum.org/sites/default/files/uploaded-related-files/Monograph_SustainHealthSpend_Nov2012_Final_0.pdf.

Center for American Progress’s “Medicare Extra for All” proposal and the Urban Institute’s “Healthy America” plan.^{194,195,196} This new public insurance program, also called AmeriCare would absorb most existing public healthcare spending and be open to all citizens and legal residents under age 65.

Figure 5: Consolidation and reform of the U.S. Healthcare System

Current Framework			Proposed Framework - 2025		
Percent Covered (2017)		Public Cost in Billions (2017)	Percent Covered (2025)		Public Cost in Billions (2017)
14%	Medicare	\$583 ^t	18%	Medicare	\$583 + \$167 ^t
				Part E: Includes Medicaid Age 65+	\$84 + \$39
49%	Employer-Sponsored Insurance	N/A	20%	Employer-Sponsored Insurance	N/A
	ESI Tax Exclusion ^{**}	\$287		AmeriCare ^y + Private Supplemental Plans	\$548 + 42 ^x Existing
7%	Marketplaces	N/A			302.9 New Revenue ^w
	ACA Subsidies	\$40	61%		\$287 ESI Tax Exclusion
21%	Medicaid Under Age 65	\$508			
	Medicaid Age 65+	\$84			
9%	Uninsured	N/A	1.3%	Uninsured	\$N/A
100%	TOTAL ^v	\$1,502	100%	TOTAL ^v	\$2,053

¹⁹⁴ Dylan Matthews. "This Old Bill could be the Secret to Affordable Universal Health Care." *Vox*, February 3, 2016. <https://www.vox.com/2016/2/3/10899790/single-payer-americanicare>.

¹⁹⁵ CAP Health Policy Team. "Medicare Extra for All." *Center for American Progress*, February 22, 2018. <https://www.americanprogress.org/issues/healthcare/reports/2018/02/22/447095/medicare-extra-for-all/>.

¹⁹⁶ Stephen Zuckerman, John Holahan, and Linda Blumberg. "The Healthy America Program." *The Urban Institute*, May 11, 2018. https://www.urban.org/sites/default/files/publication/98432/2001826_2018.05.11_healthy_america_final_1.pdf.

Data Sources: The Center for Medicare and Medicaid Services and the U.S. Census Bureau via The Kaiser Family Foundation.^{197,198}

Note: Data is from 2017; may not sum to totals due to rounding; 2025 figures are controlled for inflation to isolate spending due to policy changes from annual price increases; red numbers represent new spending.

**Medicaid and Medicare dual-eligibles, who currently receive LTC through Medicaid, would receive these benefits through a combination of Medicare and private coverage. Cost estimate includes existing Medicaid LTC spending and an estimate of the costs of mandatory back-end public coverage.*¹⁹⁹

***Also includes small-employer tax credits and the deduction for self-employed health insurance.*

*^t Cost does not include beneficiary premiums. Medicare-eligible proportion of the population is increasing due to the aging of the U.S. population. Medicare spending will automatically increase to cover new enrollees.*²⁰⁰

*^v Does not include "Other Public" spending that totaled \$218 billion in 2017, such as Indian Health Service, Department of Veteran's Affairs, and Department of Defense programs.*²⁰¹

*^x Additional federal funding that would be spent if all states expanded Medicaid: this is included in the 2017 total. Funding for Medicaid is shared by the states (38%) and federal government (62%).*²⁰²

*^y Cost of AmeriCare extrapolated using Medicaid coverage cost with Medicare reimbursement rates.*²⁰³

*^w Savings of \$95 billion from all-payer global payment reforms are subtracted from needed revenues.*²⁰⁴

As depicted in Figure 5 above, AmeriCare would co-opt the Affordable Care Act's premium tax credits and cost-sharing subsidies as well as the majority of federal and state Medicaid and CHIP spending. Existing Medicaid funds currently spent on long-term care for older people would be allocated towards a new Medicare long-term care plan.

¹⁹⁷ "Health Insurance Coverage of the Total Population." *The Kaiser Family Foundation*, 2018.

<https://www.kff.org/other/state-indicator/total-population/>.

¹⁹⁸ NHE Tables." *Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, 2019. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip>.

¹⁹⁹ Melissa M. Favreault, Howard Gleckman, and Richard W. Johnson. "Financing Long-Term Services and Supports: Options Reflect Trade-Offs for Older Americans and Federal Spending." *Health Affairs*, December 26, 2015. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1226>.

²⁰⁰ "The Next Generation of Medicare Beneficiaries." *The Medicare Payment Advisory Commission*, June 2015. <http://www.medpac.gov/docs/default-source/reports/chapter-2-the-next-generation-of-medicare-beneficiaries-june-2015-report-.pdf?sfvrsn=0>.

²⁰¹ NHE Tables." *Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, 2019. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip>.

²⁰² CAP Health Policy Team. "Medicare Extra for All." *Center for American Progress*, February 22, 2018. <https://www.americanprogress.org/issues/healthcare/reports/2018/02/22/447095/medicare-extra-for-all/>.

²⁰³ "Medicaid-to-Medicare Fee Index." *The Kaiser Family Foundation*, 2017. <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/>.

²⁰⁴ Sharfstein, et al. "An Emerging Approach to Payment Reform: All-Payer Global Budgets for Large Safety-Net Hospital Systems." *The Commonwealth Fund*, August 16, 2017. <https://www.commonwealthfund.org/publications/fund-reports/2017/aug/emerging-approach-payment-reform-all-payer-global-budgets-large>.

State funding has, by design, constituted a significant proportion of overall Medicaid spending throughout the program's history—nearly 40% of the total in 2017, or \$222 billion.²⁰⁵ Borrowing from the Urban Institute plan, states under this proposal “would be required to continue contributing what they currently do to Medicaid and CHIP.”

However, the issue of Medicaid expansion funding represents a more complex challenge. One of the primary features of the Affordable Care Act, the Medicaid expansion eased eligibility standards to allow millions of additional low-income people to enroll in the program. However, the Supreme Court struck down the ACA's requirement that all states must accept the new Medicaid funds, on the basis that Medicaid itself is technically optional for the states.²⁰⁶ These Medicaid expansion funds, seemingly an offer the states wouldn't refuse, suddenly became a political flashpoint reflecting stark divides between Democratic- and Republican-leaning states.

As of early 2019, over half of the states have expanded Medicaid, yet the remaining holdout states have caused \$42 billion in annual federal funds to be left unspent.²⁰⁷ This proposal would utilize these untapped Medicaid funds, preventing federal policymakers from being dependent on state-level decisions. Under current law, the federal government will pay for 90% of Medicaid expansion costs by 2020. This proposal would push the

²⁰⁵ NHE Tables." *Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, 2019. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip>.

²⁰⁶ David Schwartz. "Why John Roberts should have Listened to John Marshall." *The Atlantic*, December 18, 2018. <https://www.theatlantic.com/ideas/archive/2018/12/chief-justice-roberts-made-texas-obamacare-mess/578371/>.

²⁰⁷ "State and Federal Spending Under the ACA." *The Medicaid and CHIP Payment and Access Commission*, 2017. <https://www.macpac.gov/subtopic/state-and-federal-spending-under-the-aca/>.

federal portion up to 100% permanently, requiring additional federal spending totaling \$7.71 billion in 2019 and 93.8 billion over 10 years.²⁰⁸

AmeriCare's design would be based on elements of Medicaid and Medicare. Just as in Medicaid, people with incomes under 150% of the Federal Poverty Level (FPL) would not be charged premiums.²⁰⁹ AmeriCare would require payment of annual premiums for people with incomes above 150% FPL, with premiums reflecting those currently paid by Medicare beneficiaries. AmeriCare would replicate Medicaid's very minimal point-of-service cost-sharing—i.e. deductibles, copays and coinsurance—for those under 150% FPL, while for those above this level cost sharing would be based on the higher Medicare rates.²¹⁰ The benefits offered by these new public plans would be identical to the Essential Health Benefits established by the Affordable Care Act. As a result of these regulatory standards, no one covered under AmeriCare would be underinsured. Also, this legislation would restore the individual mandate to ensure adequate risk pooling.

This proposal seeks to remove the de jure supports for employer-sponsored health insurance. The employer mandate would be repealed and the ESI tax exclusion eliminated. Similar to the Center for American Progress plan, everyone who is uninsured

²⁰⁸ Juliette Cubanski and Patricia Neuman. "Medicare Eligibility, Beneficiary Costs, and Program Financing." *The Kaiser Family Foundation*, January 29, 2013. <https://www.kff.org/report-section/section-1-medicare-eligibility-beneficiary-costs-and-program-financing/>.

²⁰⁹ Brooks, et al. "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies." *The Kaiser Family Foundation*, January 12, 2017. <https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2017-premiums-and-cost-sharing/>.

²¹⁰ Brooks, et al. "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies." *The Kaiser Family Foundation*, January 12, 2017. <https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2017-premiums-and-cost-sharing/>.

or who previously purchased a private marketplace plan would be automatically enrolled in AmeriCare.²¹¹ Furthermore, every newborn child would be automatically enrolled.²¹²

This proposal would allow for a system of private, supplemental plans to enable AmeriCare beneficiaries to spend additional funds on more robust coverage. Unlike Medicare Advantage, these plans would not serve as a substitute to the public program; duplicative services would not be allowed on this market, but rather these plans could offer dental or vision coverage not covered by AmeriCare or shorter wait times, boutique personalized care, or more prescription drug choices, among other additional services.

Long-term Care Description

Under this proposal, the \$84 billion Medicaid spends annually on long-term care for older people would be shifted into a new Medicare Part E program, which would cost a total of \$123 billion per year.²¹³ People over age 65 currently receiving LTC benefits through Medicaid would be transitioned to Medicare Part E, but Medicaid would remain the primary payer of LTC for people with disabilities under age 65.

This program is based on the Medicare Long-Term Care Services and Supports Act of 2018, sponsored by Representative Frank Pallone (D-NJ).²¹⁴ It would provide a mandatory, back-end (i.e. catastrophic) benefit with a two-year waiting period and premiums set by law. As this program would be mandatory, it would entail an individual

²¹¹ CAP Health Policy Team. "Medicare Extra for All." *Center for American Progress*, February 22, 2018. <https://www.americanprogress.org/issues/healthcare/reports/2018/02/22/447095/medicare-extra-for-all/>.

²¹² Ibid

²¹³ Steve Eiken, Kate Sredl, Brian Burwell, and Angie Amos. "Medicaid Expenditures for Long-Term Services and Supports in FY 2016." *Center for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, May 2018. <https://www.medicaid.gov/medicaid/lts/downloads/reports-and-evaluations/ltssexpenditures2016.pdf>.

²¹⁴ "The Medicare Long-Term Care Services and Supports Act of 2018 Fact Sheet." *U.S. House of Representatives Committee on Energy and Commerce*, May 2018. <https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/LTSS%20Act%20Fact%20Sheet%20May%202018.pdf>.

coverage mandate similar to the ACA, levying tax penalties on those not covered. Private long-term care insurance would be given a specific role to play in the system, providing optional, affordable coverage for the first two years of care before Part E kicks in.

Cost Control Description

The purpose of this secondary proposal is to slow long-term healthcare cost growth to a sustainable rate. This would be accomplished by creating a stakeholder-driven federal body to administer an all-payer condition-adjusted global payment system with authority over all public and private healthcare spending in the country. The goal would be to limit health spending to 1.9% annual growth over the next 10 years, matching GDP growth projections.²¹⁵ As a result, healthcare spending would grow 3.6 percentage points slower per year over this time period compared with current law.²¹⁶

In all-payer systems, a decision-making body “sets reimbursement rates so that hospitals (and in this case, drug companies, doctors, nurses and other health providers) receive the same payment for any given service from all payers,” as explained by the Lown Institute.²¹⁷ This proposal’s federal decision-making body would have authority over a German-style multi-stakeholder decision making process, allowing the federal government to negotiate with health providers to set a uniform payment schedule.²¹⁸

Unlike in Germany where each state negotiates with its local care providers, this proposal would create a federal body to match the national scale of American healthcare

²¹⁵ “Economic Research—Gross Domestic Product.” *Federal Reserve Bank of St. Louis*, 2018. <https://fred.stlouisfed.org/series/GDP>.

²¹⁶ “An Update to the Economic Outlook: 2018 to 2028.” *Congressional Budget Office, U.S. Congress*, August 2018. <https://www.cbo.gov/publication/53651>.

²¹⁷ “Maryland’s all-Payer System shows Hospitals can Live within their Means.” *Lown Institute*, 2017. <https://lowninstitute.org/news/marylands-payer-system-shows-hospitals-can-live-within-means/>.

²¹⁸ Miriam Blumel and Reinhard Busse. “The German Health Care System.” *The Commonwealth Fund*. <https://international.commonwealthfund.org/countries/germany/>.

companies, though it would account for regional differences. This body would be an independent non-profit entity created by the Department of Health and Human Services, and start-up costs would be folded into overall AmeriCare costs.

The “condition-adjusted” element of this proposal refers to a model borrowed from policy analyst Harold Miller which alters the traditional capitation system. In traditional capitation, overall “global” provider payments are based on a range of performance-based quality measures, such as hospital readmissions.²¹⁹ Under condition-adjusted capitation, these performance-based payments “would be adjusted based on the health of the patients and other characteristics that affect the level of services needed, such as language barriers,” as described by Miller.²²⁰ Such a model provides an incentive for providers to deliver better quality care while ensuring providers aren’t unfairly penalized for factors outside of their control.

The “global” aspect of this proposal, borrowed from Rep. Pramila Jayapal’s (D-WA) single payer bill, refers to a bundled pre-payment to health providers covering “all of a population of patients’ health care needs over the course of a year,” as described by the Urban Institute.^{221,222} The cost of care needed to address the population’s health needs would be determined using the fee schedule developed by the all-payer decision-making process. In other words, though the government would set the overall target for growth in health spending at 1.9% per year, this multi-stakeholder group would be tasked with

²¹⁹ Harold D. Miller. "From Volume to Value: Better Ways to Pay for Health Care." *Health Affairs*, September 2009. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.28.5.1418>.

²²⁰ Ibid

²²¹ U.S. Representative Pramila Jayapal. "Text - H.R.1384 - 116th Congress (2019-2020): To Establish an Improved Medicare for all National Health Insurance Program." *U.S. Congress*, February 27, 2019. <https://www.congress.gov/bills/116/congress/house-bill/1384/text>.

²²² Rachel Burton, Francois de Brantes, and Robert Berenson. “Payment Reform: Bundled Episodes vs. Global Payments.” *The Urban Institute*, September 2012 <https://www.urban.org/sites/default/files/publication/25816/412655-Payment-Reform-Bundled-Episodes-vs-Global-Payments.PDF>.

fairly apportioning cost growth across the myriad health products and services used by consumers in a given year. Contrary to Jayapal’s plan, not only would hospitals be subject to global budgeting, but all health professionals, pharmaceuticals, medical devices, and diagnostic tools would be covered as well. Based on the results of Maryland’s similar rate-setting system, this proposal—implemented in conjunction with the AmeriCare insurance expansion—could save \$95 billion in the first full year and \$1.15 trillion over 10 years.²²³ For more on the assumptions behind these figures, see the *Policy Analysis* section of this memo.

Policy Implementation Tools

The policy implementation tools utilized for this proposal’s coverage expansion include two new entitlement programs (AmeriCare and Medicare Part E), each paired with a “stick” or tax penalty for consumer non-participation. These programs would be implemented over a five-year transition period—2020 through 2025—to allow the new systems to be stood up and to provide time for the various affected stakeholders to adjust to these changes. The implementation tool used for the cost control aspect of this proposal would be an independent, non-profit, non-governmental organization empowered to set healthcare prices through a negotiated process. This element would be implemented as soon as possible—just one year after the law’s passage—to avoid the

²²³ Sharfstein, et al. “An Emerging Approach to Payment Reform: All-Payer Global Budgets for Large Safety-Net Hospital Systems.” *The Commonwealth Fund*, August 16, 2017. <https://www.commonwealthfund.org/publications/fund-reports/2017/aug/emerging-approach-payment-reform-all-payer-global-budgets-large>.

political risk of being repealed or delayed indefinitely before taking effect, (see the SGR example mentioned in the *History and Background* section).²²⁴

The Center for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services, would be renamed the Center for Medical Services and be tasked with administering the coverage expansion. To ensure CMS can properly implement and administer AmeriCare and Medicare Part E, funding for staff salaries would more than double, from \$723 million in 2018 to \$1.72 billion in 2020.²²⁵ Additionally, \$20 billion would be allocated as start-up costs for these new federal programs, including the new rate setting organization. This is in comparison to the \$8 billion allocated to create the ACA exchanges.²²⁶

This proposal specifically targets the uninsured and underinsured, the lower-income Medicaid population and those eligible for marketplace subsidies. Because racial and ethnic minorities are disproportionately represented among lower-income populations, members of these groups would stand to benefit significantly from this proposal.

Ultimately, this plan would affect all consumers by setting standards for the affordability and adequacy of health insurance as well as by providing an off-ramp for anyone unhappy with their current employer-sponsored insurance. The availability of public AmeriCare insurance plans would also vastly decrease the revenues the private health insurance industry. The long-term care element of this proposal also is targeted towards

²²⁴ Billy Wynne. "May The Era Of Medicare's Doc Fix (1997-2015) Rest In Peace. Now What?" *Health Affairs*, April 15, 2015. <https://www.healthaffairs.org/doi/10.1377/hblog20150415.046932/full/>.

²²⁵ "FY 2018 Justification of Estimates for Appropriations Committees." *Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services*, 2017. <https://www.cms.gov/about-cms/agency-information/performancebudget/downloads/fy2018-cj-final.pdf>.

²²⁶ David Himmelstein and Steffie Woolhandler. "The Post-Launch Problem: The Affordable Care Act's Persistently High Administrative Costs." *Health Affairs*, May 27, 2015. <https://www.healthaffairs.org/doi/10.1377/hblog20150527.047928/full/>.

potentially everyone, i.e. all people who ultimately could be subjected to catastrophic care costs as they age. Finally, the cost control aspect of this proposal is targeted towards hospitals, nurses, doctors, other health providers, and pharmaceutical and medical device companies, all of which would see lower reimbursement growth going forward.

Paying for the Proposal

As depicted in Table 3 below, this proposal overall would require \$413 billion in additional revenue in the first year and \$4.99 trillion over 10 years.²²⁷ AmeriCare and Medicare Part E, when fully implemented in 2025, will cost approximately \$1.303 trillion that year (using 2017 dollars for comparison's sake).²²⁸ Existing spending would fund roughly 70% of the new programs, to the tune of \$919 billion, including the \$95 billion in savings from the all-payer global payment system.²²⁹ The remaining costs—\$383.9 billion over one year or \$4.41 trillion over 10 years—would be addressed by increasing the Hospital Insurance payroll tax by 8.18 percentage points, from 2.9% to 11.08%, divided evenly between employers and employees.^{230,231}

To pay for federalizing the remaining 10% of Medicaid expansion funding, a 2.66% tax would be levied on unearned income, raising \$7.71 billion in 2019 and 93.8 billion over

²²⁷ "NHE Tables." *Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, 2019. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip>.

²²⁸ Ibid

²²⁹ Sharfstein, et al. "An Emerging Approach to Payment Reform: All-Payer Global Budgets for Large Safety-Net Hospital Systems." *The Commonwealth Fund*, August 16, 2017. <https://www.commonwealthfund.org/publications/fund-reports/2017/aug/emerging-approach-payment-reform-all-payer-global-budgets-large>.

²³⁰ Melissa M. Favreault, Howard Gleckman, and Richard W. Johnson. "Financing Long-Term Services and Supports: Options Reflect Trade-Offs for Older Americans and Federal Spending." *Health Affairs*, December 26, 2015. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1226>.

²³¹ "Increase the Payroll Tax Rate for Medicare Hospital Insurance." *Congressional Budget Office, U.S. Congress*, December 13, 2018. <https://www.cbo.gov/budget-options/2018/54804>.

10 years.²³² This would add onto the ACA's 3.8% tax on unearned income, which the Kaiser Family Foundation defines as "net investment income for taxpayers with modified adjusted gross income in excess of \$200,000 for singles and \$250,000 for married couples."²³³

Table 3: Current and Proposed National Health Expenditures by Sponsor

Type of Sponsor	Current		Proposed		New Revenues
	Percent	Total	Percent	Total*	
National Health Expenditures	100.0%	\$3,492.1	100.0%	\$3,879	
Private Spending	54.8	1,914.1	37.6	1461	
Private Business ^a	26.7	935.5	18.5	721	
Household ^b	28.0	978.6	19.1	740	
Public Spending (Federal and State)	34.8	1,213.3	52.9	2053.3	
Medicare	16.7	583	19.3	750***	167 - Mandatory Spending
AmeriCare + LTC Consolidation	18.1	632.4	33.3	1303	670.9 - 287 ESI exclusion = 383.9
Other State and Local	10.4	364.7	9.5	364.7	

*Data Source: Centers for Medicare and Medicaid Services, 2017.*²³⁴

Note: Totals may not be exact because of rounding.

**Includes projected \$95 billion savings, additional \$39 billion in LTC spending and additional \$293 billion in spending on the newly insured. CMS does not count ESI tax exclusion as a health expenditure.*

****Increased due to aging of population by full implementation in 2025.*

a Assumes a 40% cut in ESI contributions.

²³² Juliette Cubanski and Patricia Neuman. "Medicare Eligibility, Beneficiary Costs, and Program Financing." *The Kaiser Family Foundation*, January 29, 2013. <https://www.kff.org/report-section/section-1-medicare-eligibility-beneficiary-costs-and-program-financing/>.

²³³ Ibid

²³⁴ "NHE Tables." *Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, 2019. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip>.

b Assumes a 20% cut in out-of-pocket expenses, a 40% cut in ESI contributions, and elimination of private individual market.

The additional CMS staff salaries, requiring \$1 billion in new spending by 2025, would be funded by a tax of 1 cent on every 12 ounces of sugar-sweetened beverages, which the CBO estimates would result in \$1.4 billion in additional revenues.²³⁵ To pay for the \$20 billion in start-up costs, a one-time tax would be levied on the financial industry, recapturing the windfall received by the industry in 2018 due to the Tax Cuts and Jobs Act of 2017.²³⁶ Ideally, this tax law would be repealed and the additional revenues used to decrease annual deficits.

Policy Analysis

AmeriCare Proposal Analysis

This proposal would add 23.5 million people to the ranks of the insured, decreasing the uninsured rate to 1.3%, nearly in line with the 0.1% average rate among similarly wealthy countries.²³⁷ This figure would remain above one percent because although the plan covers all citizens and legal residents, undocumented immigrants would not be eligible as is the case with Social Security, Medicare, and the ACA (some emergency services are available to undocumented immigrants through Medicaid, which would be preserved under AmeriCare).²³⁸ As a result, 3.9 million people—all undocumented immigrants—

²³⁵ Ibid

²³⁶ Ben Foldy. "U.S. Banks Win \$21 Billion Trump Tax Windfall Then Cut Staff, Loaned Less." *Bloomberg Politics*, February 6, 2019. <https://www.bloomberg.com/news/articles/2019-02-06/banks-reaping-21-billion-tax-windfall-cut-staff-ease-off-loans>.

²³⁷ Rabah Kamal. "The U.S. has the Lowest Insured Rate of all Comparable Countries." *Peterson-Kaiser Health System Tracker*. April 21, 2017. <https://www.healthsystemtracker.org/chart/u-s-lowest-insured-rate-comparable-countries/>.

²³⁸ Ciara O'Rourke. "No, undocumented immigrants don't get Medicare for free." *PolitiFact*, February 27, 2019. <https://www.politifact.com/facebook-fact-checks/statements/2019/feb/27/facebook-posts/no-undocumented-immigrants-dont-get-medicare-free/>.

would remain uninsured.²³⁹ Ideally, Congress will pass comprehensive immigration reform, providing a path to citizenship, or at least legal status, for undocumented immigrants. Such a development would push the uninsured rate down to .01% or lower.

This proposal would come very close to achieving universal health coverage, only failing to entirely solve the problem because of an unresolved policy issue outside its scope. If passed by Congress, the likelihood of this proposal's success is high, considering that the new mandatory coverage option would be accessible and affordable to all. Recent precedent also points to the high potential for success: Medicare and Medicaid were limited to older and lower-income people, respectively for political rather than policy reasons. But there is no reason to think that a more expansive iteration of these programs could not succeed as designed.

This proposal provides many benefits. Auto-enrolling the uninsured and those covered by Medicaid and ACA marketplace plans would ensure rapid progress towards universal coverage, while minimizing care disruptions to those already receiving public assistance. Second, universal availability of affordable and adequate health insurance would eliminate both uninsurance and underinsurance, improving health outcomes and decreasing the number of people who struggle to pay their medical bills. This would improve the overall financial situations of millions of lower-income Americans.²⁴⁰ Third, while studies have long shown that wealthier countries spend more money on healthcare, generally leading to better health outcomes, recent research has uncovered a virtuous

²³⁹ "Key Facts about the Uninsured Population." *The Kaiser Family Foundation*, December 7, 2018.

<https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

²⁴⁰ Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Samantha Artiga. "The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review." *The Kaiser Family Foundation*, March 28, 2018. <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/>.

cycle, finding that “better health can lead to higher incomes” as an article from the Economist put it.²⁴¹ And so, providing health insurance coverage to all Americans would ensure these societal benefits are fully realized.

In total, this proposal would require \$413 billion in additional revenue in the first year and \$4.99 trillion over 10 years.²⁴² Approximately 183 million Americans would be covered by AmeriCare in 2025 at a cost of \$2,350 per person.²⁴³ Furthermore, those under 150% of FPL would pay no premiums, and while the average person would pay limited premiums, their overall healthcare costs would generally be lower. Under AmeriCare, most people’s costs would be similar to those paid currently by Medicare beneficiaries: \$2,130 per year including prescription drugs (total Medicare out-of-pocket costs are higher on average, but these figures are not comparable because AmeriCare beneficiaries would be younger and healthier than the Medicare population).²⁴⁴ Currently, ESI premium and deductible costs average \$2,434 per year for individuals, meaning that the average worker covered by AmeriCare would save \$304 per year.²⁴⁵ Individuals who purchased ACA marketplace plans would save far more money. The average unsubsidized premium and deductible cost is \$9,813 for an individual, meaning that AmeriCare would save such an individual \$7,683 annually, though this figure does not

²⁴¹ John McDermott. “Both in rich and poor countries, universal health care brings huge benefits.” *The Economist*, April 28, 2018. <https://www.economist.com/special-report/2018/04/28/both-in-rich-and-poor-countries-universal-health-care-brings-huge-benefits>.

²⁴² “NHE Tables.” *Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, 2019. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip>.

²⁴³ “Health Insurance Coverage of the Total Population.” *The Kaiser Family Foundation*, 2018. <https://www.kff.org/other/state-indicator/total-population/>.

²⁴⁴ “Is Medicare’s coverage as good as my employer-sponsored insurance?” *Medicare Resources*, March 17, 2018. <https://www.medicareresources.org/faqs/is-medicare-coverage-as-good-as-my-employer-sponsored-insurance/>.

²⁴⁵ Ibid

account for the subsidies most people receive to purchase insurance from the exchanges.²⁴⁶

When considering the increased tax burden required for this proposal, the figures above become less generous. The proposal would require 151 million people employed in non-contingent arrangements to pay \$192 billion in additional payroll tax revenues, translating into an average tax increase of \$1,271 per worker.^{247,248} As a result, people with ESI plans could pay higher overall costs in the short term—an average of \$967 more per year. It is likely that employer-provided plans would become less valuable once the tax exclusion is repealed, making AmeriCare more attractive to consumers. For those with unsubsidized ACA marketplace plans, individuals would save an average of \$5,782 after taxes.²⁴⁹ If annual cost growth were successfully limited to 1.9%, consumers would spend thousands less on healthcare by 2025, making the figures in the previous paragraph more advantageous for consumers.

A scaled-down version of this proposal could be considered as a way to mitigate costs to the federal government. If AmeriCare were offered only to people not covered by employer benefits, it would cover 37% of the population rather than over 60%. This alternative proposal would still consolidate Medicaid and ACA subsidies while expanding coverage to the uninsured. A back-of-the-envelope calculation reveals that this version would require \$255 billion in additional annual revenue, significantly less than

²⁴⁶ How much does Obamacare cost in 2018?" *eHealth Insurance Services*, June 20, 2018. <https://www.ehealthinsurance.com/resources/uncategorized/much-obamacare-cost-2018>.

²⁴⁷ "Employment in the United States from 2009 to 2019 (in millions)." *Statista*, 2019. <https://www.statista.com/statistics/269959/employment-in-the-united-states/>.

²⁴⁸ Karen Kosanovich. "A Look at Contingent Workers." *U.S. Bureau of Labor Statistics, U.S. Department of Labor*, September 2018. <https://www.bls.gov/spotlight/2018/contingent-workers/home.htm>.

²⁴⁹ How much does Obamacare cost in 2018?" *eHealth Insurance Services*, June 20, 2018. <https://www.ehealthinsurance.com/resources/uncategorized/much-obamacare-cost-2018>.

the original proposal. However, creating a public plan without eliminating the ESI tax exclusion (which cost \$218 billion in 2017) would be very expensive for the federal government.²⁵⁰ And eliminating the tax exclusion, while prohibiting ESI-covered workers from joining AmeriCare, would make health insurance unaffordable for millions of workers. As a result, for this scaled-down plan to “do no harm,” by preserving the tax exclusion, it would actually require an additional \$129 billion in new revenues compared with the original version and therefore would not be a superior alternative.

Single-Payer Comparison

From a budget perspective, AmeriCare compares favorably to single-payer proposals such as Senator Bernie Sanders’s (D-VT) Medicare for All plan. According to the Mercatus Center at George Mason University, “Sanders’s plan proposes moving every American in the country onto a single government-run insurer... Doing so would massively increase government expenditures by as much as \$33 trillion (over a 10 year period)... it would require enormous tax increases to finance, although Sanders maintains they would be offset by zeroing out every family’s spending on premiums and deductibles.”²⁵¹

According to economist Marc Goldwein of the Committee for a Responsible Budget, “it would be almost impossible to raise \$32 trillion of taxes or finance it with extra borrowing and not create some negative GDP effects and deadweight loss (which could) exceed \$2 trillion over a decade.”²⁵² In comparison, the proposal presented in this memo requires much less new revenue because some private payers and out-of-pocket costs

²⁵⁰ “Washington Update: Future of the ESI Tax Exclusion.” *Shaw Hankins*, March 2, 2017.

<https://www.shawhankins.com/resource/tom-price-future-esi-tax-exclusion/>.

²⁵¹ Robert Graboyes. “Medicare for All: Explaining the Math.” *The Mercatus Center at George Mason University*, August 23, 2018. <https://www.mercatus.org/bridge/commentary/medicare-all-explaining-math>.

²⁵² Marc Goldwein. *Twitter*, August 9, 2018. <https://twitter.com/MarcGoldwein/status/1027646202072969218>.

would remain, and cost sharing—including premiums—would be preserved for many consumers.

Although cost sharing saves money for payers, point-of-service cost-sharing in particular is badly targeted. It forces consumers to make decisions about which care to forgo, something only health providers are qualified to do. Annual premiums are a form of cost sharing that do not affect consumer care decisions, though high premiums can cause people to become uninsured. Despite the high cost, eliminating cost sharing outright as proposed by Sanders would likely improve American's health outcomes and should be considered by future policy makers.

Effects of Consolidating Existing Programs

The consolidation of multiple public healthcare programs into one universal-eligibility national insurer would end the complex, unwieldy patchwork of coverage currently experienced by Americans. Not only would most of the long-term uninsured be covered, but people would no longer have to worry about losing coverage due to unexpected life events, such as job loss, divorce, or the death of a spouse or parent.

AmeriCare would end the healthcare earnings cliff, wherein small increases in income can result in the loss of Medicaid and ACA benefits. Prior to the ACA, working parents lost access to Medicaid coverage at well below the federal poverty level, when their incomes reached just \$12,000 per year. The Medicaid expansion helped alleviate this cliff in states where it was implemented by extending eligibility above the FPL, complementing the ACA subsidies available to households up to 400% of the poverty

level.²⁵³ AmeriCare would effectively expand Medicaid in all states as well as further smooth the earnings cliff, providing certainty and simplicity to Americans as they move across the income spectrum.

AmeriCare also would provide much-needed support for middle-income people who did not previously qualify for public assistance. Middle-income families would no longer have to struggle with rapidly rising premiums and other out-of-pocket expenses. This includes underinsured households covered by employer-sponsored plans, as anyone not satisfied with their current plan could switch to AmeriCare.

Impact on ESI

This proposal would decouple employee wages from health coverage. Employers no longer would be directly responsible for employee health costs, but these savings would not translate into immediate wage increases because corporate profits are generally passed on to shareholders rather than workers.²⁵⁴ And the higher payroll tax burden required by AmeriCare would eat into the employer savings. However, in the longer-term companies wouldn't be able to credibly use rising health costs as an excuse for not raising wages. Furthermore, AmeriCare would end both employee "job lock" and the employer responsibility to provide health benefits. Taken together, these changes would remove healthcare as a barrier to entrepreneurship, potentially increasing the dynamism of the U.S. economy.

²⁵³ Sharon Parrot and Robert Greenstein. "Policymakers Often Overstate Marginal Tax Rates for Lower-Income Workers and Gloss Over Tough Trade-Offs in Reducing Them." *The Center on Budget and Policy Priorities*, December 3, 2014. <https://www.cbpp.org/research/policymakers-often-overstate-marginal-tax-rates-for-lower-income-workers-and-gloss-over>.

²⁵⁴ Joseph E. Stiglitz. "The American Economy Is Rigged." *Scientific American*, November 1, 2018. <https://www.scientificamerican.com/article/the-american-economy-is-rigged/>.

A major consideration of this proposal was giving consumers—specifically, the nearly half of Americans who receive ESI—a choice between keeping their private health insurance coverage and moving to the new public plan. Decentering ESI would make employers less likely to offer health benefits, and so many employees might be forced to give up their current plan, regardless of their own preference. Auto-enrolling newborns in AmeriCare would undermine ESI in the long term, though many larger employers may retain health insurance as an employee benefit until the benefits of this new system are proven. Employers might eventually offer payments towards supplemental plans as an employee benefit.

Phasing out the ESI tax exclusion over five years—as this proposal does—would give employers and workers time to adjust to the new reality. The CBO estimated that removing the tax exclusion without creating an affordable public plan would decrease the number of people with ESI plans by 10%.²⁵⁵ However, a Commonwealth Fund analysis of Congressman Pete Stark’s 2005 bill (one of the inspirations for this memo’s proposal) found that the availability of robust public plan could lower the share of Americans with ESI to a mere 1%.²⁵⁶ This study suggests that AmeriCare could shift a significant number of Americans from private to public coverage. However, because the payment reforms

²⁵⁵ Robert Pear. "86 Percent of Health Law Enrollees Receive Subsidies, White House Says." *The New York Times*, March 11, 2015. <https://www.nytimes.com/2015/03/11/us/11-7-million-americans-have-insurance-under-health-act.html>.

²⁵⁶ Sara Collins, Jennifer Nicholson, and Sheila Rustgi. "An Analysis of Leading Congressional Health Care Bills." *The Commonwealth Fund*, January 2009. https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_fund_report_2009_jan_an_analysis_of_leading_congressional_health_care_bills_2007_2008_part_i.

would apply to all types of insurance, this memo’s version of AmeriCare would merely level the playing field with ESI rather than overtly attempt to displace it.²⁵⁷

Supplemental Plans and Preserving Innovation

The addition of private supplemental plans to AmeriCare would allow wealthier Americans to buy more robust coverage if they chose to. This would preserve the idea that America “has the best healthcare in the world as long as you can afford it,” while ensuring that everyone has access to a very good baseline of care.²⁵⁸ Furthermore, the wealthy paying more could sustain some of the cost inefficiencies that stimulate the development of advanced pharmaceuticals, medical devices, and surgical procedures.²⁵⁹ According to the Brookings Institution, “higher expected revenues leads to more drug discovery... on average every \$2.5 billion of additional revenue leads to a new drug approval.”²⁶⁰ In fact, the U.S. spends twice as much per capita on pharmaceuticals compared to European countries, but is also responsible for a disproportionate amount of the new drugs discovered annually.²⁶¹ Under AmeriCare, pharmaceutical industry revenues—and therefore drug discoveries—would be lower compared with current law, but higher than without the supplemental plans.

²⁵⁷ U.S. Representative Pramila Jayapal. “Text - H.R.1384 - 116th Congress (2019-2020): To Establish an Improved Medicare for all National Health Insurance Program.” *U.S. Congress*, February 27, 2019.

<https://www.congress.gov/bills/116/congress-house/bills/1384/text>.

²⁵⁸ Aaron E. Carroll and Austin Frakt. “The Best Health Care System in the World: Which One Would You Pick?” *The New York Times*, September 18, 2017. <https://www.nytimes.com/interactive/2017/09/18/upshot/best-health-care-system-country-bracket.html>.

²⁵⁹ Dana Goldman and Darius Lakdawalla. “The Global Burden of Medical Innovation.” *The Brookings Institution*, January 30, 2018. <https://www.brookings.edu/research/the-global-burden-of-medical-innovation/>.

²⁶⁰ Ibid

²⁶¹ Ibid

Potential Drawbacks

A major issue with expanding coverage to all Americans is ensuring sufficient health system capacity. As single-payer advocate Matt Bruenig notes, there may not be enough doctors, nurses, and hospitals to care for the additional millions of Americans who would be covered under a universal system. In Bruenig's words, "you can work to try to increase supply. Make it easier to become a doctor. Make it easier for doctors abroad to come to the US. But can you do that quickly enough to handle demand that you might have?"²⁶² And so, insufficient provider supply is likely an unavoidable problem when transitioning to universal healthcare, particularly considering the lower reimbursement rates which could lead to fewer people entering the medical profession. This could translate into drastically longer wait times for care in the shorter term. But wait times would presumably stabilize once the system adapts (e.g. using telehealth and expanding nurse scope of practice) and supply catches up with demand.

The capacity of the federal government, specifically CMS, could prove insufficient to implement AmeriCare in a timely and effective manner. For example, the Affordable Care Act's federal insurance marketplace website crashed the morning it went live in 2013.²⁶³ Less than one-fifth of the U.S. population might have been eligible for a plan on Healthcare.gov that day, and in fact nearly 3 million people were visiting the website when it crashed. But the launch of a universal coverage program would create a problem of much greater scale, conceivably drawing tens of millions of visitors to the registration website on the first day of open enrollment.

²⁶² Dylan Scott. "A single-payer advocate answers the big question: How do we pay for it?" *Vox*, March 4, 2019. <https://www.vox.com/policy-and-politics/2019/3/4/18249888/medicare-for-all-cost-matt-bruenig-voxcare>.

²⁶³ Wyatt Andrews and Anna Werner. "Healthcare.gov plagued by crashes on 1st day." *CBS News*, October 1, 2013. <https://www.cbsnews.com/news/healthcaregov-plagued-by-crashes-on-1st-day/>

On the other hand, if AmeriCare were to succeed but the cost control element failed, the U.S. government would end up placing a much larger percentage of overall health spending on its books. Given current projections, healthcare costs in this scenario would overwhelm the federal budget much quicker than under current law. Also, while AmeriCare is significantly less costly than recent single payer proposals, the tax increases could still crowd out private spending and create deadweight loss.²⁶⁴

Another drawback is related to the method chosen for funding AmeriCare. The payroll tax is a flat, regressive tax, meaning that lower-income people pay a higher percentage of their incomes in payroll taxes compared to wealthier people. Furthermore, though employers pay half of all payroll taxes, employees effectively shoulder the entire burden of these taxes in the form of lower wages.²⁶⁵ And payroll tax revenues are highly dependent on economic conditions, specifically the job market. A downturn could mean insufficient revenues to fund the program when at the same time more people need public assistance. Despite the problems with the payroll tax, it is an effective method of capturing the broad swath of revenue needed for such a significant expansion of government.

A potential source of risk to this proposal could arise from states unhappy with their Medicaid contributions being co-opted by a universal program. Some states might opt to cease their contributions to Medicaid's successor, while court cases might be filed arguing that the federal government can't force states to spend funds on a new program that were originally intended for Medicaid.

²⁶⁴ Marc Goldwein. *Twitter*, August 9, 2018. <https://twitter.com/MarcGoldwein/status/1027646202072969218>.

²⁶⁵ John Olsen. "What Are Payroll Taxes and Who Pays Them?" *Tax Foundation*, July 25, 2016. <https://taxfoundation.org/what-are-payroll-taxes-and-who-pays-them/>.

Finally, an important downside of private supplemental plans to consider is the possibility that the supplemental plans would create a two-tier framework with vast differences in care based on what people can afford. Given the consumer experience with Medicare Advantage, it's likely that the disparities would be limited and potentially ameliorated through regulation.

Long-term Care Proposal Analysis

Medicare Part E, the mandatory catastrophic long-term care plan proposed in this memo, exposes the federal government to significant but manageable costs when compared to a comprehensive plan. This public plan costs less because it is supplemented with private “front-end insurance,” enabling the private sector to profit while sharing some of the financial burden. Such a plan needs to be mandatory because, according to the Heritage Foundation, “insurance products that must offer coverage to any applicant at a uniform rate (i.e., guaranteed issue) and are voluntary are likely to unravel from adverse selection...”²⁶⁶ The ACA originally included an individual mandate for the same reason.

This proposal would transfer all Medicaid long-term care costs for people over 65 to Medicare. Doing so would enable better care coordination (and therefore better outcomes), streamlined payments, and aligned cost-control incentives.²⁶⁷ And such a system would prevent older people from having to exhaust their savings to pay for LTC.

²⁶⁶ Brian Blase. “Obamacare and the CLASS Act: Creating a Long-Term Care Entitlement Burden.” *The Heritage Foundation*, January 19, 2011. <https://www.heritage.org/health-care-reform/report/obamacare-and-the-class-act-creating-long-term-care-entitlement-burden>.

²⁶⁷ Caroline Brown and Anna Kraus. “Medicare and Medicaid: When Two Is Not Better Than One.” *The Atlantic*, May 22, 2012. <https://www.theatlantic.com/health/archive/2012/05/medicare-and-medicaid-when-two-is-not-better-than-one/257298/>.

Americans with disabilities under age 65 would remain in AmeriCare (the successor to Medicaid) rather than join Medicare Part E. This makes sense because Medicaid does a good job of catering to this population. For example, Medicaid helps working-age people with disabilities secure employment and provides school-based services for children with disabilities.²⁶⁸ These types of services would be preserved under AmeriCare.

Cost Reduction Proposal Analysis

The secondary goal of this proposal is to keep healthcare spending at a sustainable level, defined as equal to or below the projected annual GDP growth rate of 1.9%.²⁶⁹ The proposed solution is to mandate that spending growth be constrained to 1.9% annually. This may seem like circular logic, but if the prices for health services are high simply because producers and providers can charge such high prices, the solution is to fix prices at a lower level. All-payer global budgeting is a particularly effective way to approach this challenge because it enables the payers to collectively negotiate with increasingly monopolistic health providers and pharmaceutical companies in a unified, structured process.²⁷⁰ Such a process paired with spending targets would empower the federal government to drive prices down using the force of law and negotiation. All types of health providers and producers would have to adapt to lower prices, just as their counterparts in many other countries have.

²⁶⁸ "Medicaid Works for People with Disabilities." *The Center on Budget and Policy Priorities*, August 29, 2017. <https://www.cbpp.org/research/health/medicaid-works-for-people-with-disabilities>.

²⁶⁹ "Economic Research—Gross Domestic Product." *Federal Reserve Bank of St. Louis*, 2018. <https://fred.stlouisfed.org/series/GDP>.

²⁷⁰ Brian Alexander. "America's Rural Hospitals Are Dangerously Fragile." *The Atlantic*, January 8, 2018. <https://www.theatlantic.com/business/archive/2018/01/rural-hospitals/549050/>.

Under the global budgeting model, one annual bulk payment is made to providers based on anticipated population needs, rather than countless smaller payments based on the care received by individual patients. This approach decreases the incentives for providers to pursue potentially unneeded care that drives up healthcare costs. Global budgeting also prevents hospitals and other health providers from compensating for lower prices by performing more procedures per patient. In the words of Harold Miller, “a provider gets paid more for taking care of sicker patients but not for providing more services to the same patients.”²⁷¹ Because AmeriCare would displace much of the private insurance market, insurers may try to make up for the revenue loss in the supplemental market. As a result, supplemental premiums may have to be regulated or additional benefits may need to be added to the public plan.

The condition-adjusted capitation feature of this proposal would solve an issue that plagues other attempts at performance-based care. Specifically, if performance pay is based on outcomes without controlling for the original health status of patients, providers will be unfairly punished for simply treating less healthy patients. Under the current system, some providers may be less likely to accept new Medicaid patients because the program serves a vulnerable population with worse overall health outcomes.²⁷² This proposal would also lead to the end the fee-for service model, shifting the emphasis of provider payment towards quality over quantity.

²⁷¹ Harold D. Miller. "From Volume to Value: Better Ways to Pay for Health Care." *Health Affairs*, September 2009. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.28.5.1418>.

²⁷² W. Pete Welch. "Giving physicians incentives to contain costs under Medicaid." *Health Care Financing Review*, 1990. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193105/>.

Cost Savings Estimates

Successfully limiting national health spending growth to 1.9% per year from 2018-2028 would prevent the economy from being overwhelmed by healthcare costs. Without intervention, healthcare spending is projected to rise by 5.5% per year from \$3.6 trillion today to \$6.15 trillion in 2028.²⁷³ In comparison, under this proposal health spending would rise to \$4.35 trillion by 2028, saving \$1.8 trillion over 10 years for the economy as a whole, or \$180 billion per year on average.^{274, 275}

Considering that the federal government accounted for 35% of NHE in 2017, this would represent \$63 billion in annual savings. However, after this proposal is successfully implemented, the federal government would become responsible for approximately 53% of NHE and therefore the new payment mechanism could save taxpayers \$95.4 billion in the first year and \$1.15 trillion over 10 years. Successful implementation of this proposal would also ensure that healthcare costs no longer continue to rise as a percentage of GDP. Under current law, healthcare as a percentage of GDP is projected to rise to nearly 25% by 2028, while this proposal would keep this number under 18%, nearly exactly the same proportion as in 2018.²⁷⁶

²⁷³ “An Update to the Economic Outlook: 2018 to 2028.” *Congressional Budget Office, U.S. Congress*, August 2018. <https://www.cbo.gov/publication/53651>.

²⁷⁴ “National Health Expenditures 2017 Highlights.” *Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, 2018. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>.

²⁷⁵ “An Update to the Economic Outlook: 2018 to 2028.” *Congressional Budget Office, U.S. Congress*, August 2018. <https://www.cbo.gov/publication/53651>.

²⁷⁶ “National Health Expenditures 2017 Highlights.” *Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, 2018. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>.

Potential Drawbacks

Considering that healthcare comprises such a large percentage of GDP, lower health spending could actually decrease overall economic growth. Furthermore, studies have shown that the high health spending in the U.S. over the last 20 years has moderated the negative effects of recessions on economic growth.²⁷⁷

A potential downside of setting a hard cap on aggregate healthcare cost growth is that the multi-stakeholder group might conclude a 1.9% annual increase simply isn't enough to cover the costs of care. For example, lower GDP growth during economic recessions would have to be considered, as would the aging of the population leading to more Americans with complex care needs. A similar risk of the global budgeting model is that the government could underestimate the population's care needs, causing hospitals and provider practices to lose money or even go bankrupt. The Heritage Foundation argues that price setting in the healthcare context would lead to "widespread shortages (that) guarantee providers a reliable demand for substandard services and prevent them from profiting by innovating or improving quality."²⁷⁸ Hopefully the multi-stakeholder model would provide health professionals with sufficient input into the price controls, mitigating this issue. Furthermore, a lot goes into the decision to become a doctor or a nurse, and it's likely that salaries would remain high enough to draw sufficient workers to the field.

Finally, the multi-stakeholder group could become dominated by industry influence—a phenomenon known as regulatory capture—leading to less effective cost controls. It is

²⁷⁷ Jason Hockenberry and Kenneth Thorpe. "Slow Health Care Spending Growth Moderates GDP Growth in The Short Term and Policy Targets Should Reflect This." *Health Affairs*, October 16, 2014. <https://www.healthaffairs.org/doi/10.1377/hblog20141016.041820/full/>.

²⁷⁸ Christopher Pope. "Legislating Low Prices: Cutting Costs or Care?" *The Heritage Foundation*, August 9, 2013. <https://www.heritage.org/health-care-reform/report/legislating-low-prices-cutting-costs-or-care>.

the responsibility of political leaders who oversee this organization to ensure it is independent of the stakeholders it seeks to regulate.

Maryland Case Study

The global, all-payer system likely won't result in immediate cost savings to offset the need for new tax revenues. However, based on results from other countries which use such a system, including Germany, health spending growth would likely be limited to a sustainable rate over the long term. Such a system is actually not limited to European countries; there is a precedent for its implementation in the United States. The state of Maryland has had an all-payer system since the 1970s and a global budgeting framework since 2014.²⁷⁹ In both cases, Maryland's model only covers Medicare hospital costs.

Rather than the German multi-stakeholder model, Maryland has opted for a more top-down approach in which an independent commission sets rates for each type of hospital procedure.²⁸⁰ Though price growth has been lower compared to the rest of the country, per capita Medicare hospital costs were until recently among the highest in the country.²⁸¹ According to a New England Journal of Medicine study, "the system eliminated price competition between hospitals and led them to divert high-cost patients to alternative settings, where prices remained unregulated." It was this realization that

²⁷⁹ Sharfstein, et al. "An Emerging Approach to Payment Reform: All-Payer Global Budgets for Large Safety-Net Hospital Systems." *The Commonwealth Fund*. August 16, 2017. <https://www.commonwealthfund.org/publications/fund-reports/2017/aug/emerging-approach-payment-reform-all-payer-global-budgets-large>.

²⁸⁰ Rajkumar, et al. "Maryland's All-Payer Approach to Delivery-System Reform." *New England Journal of Medicine*, February 6, 2014. <https://www.nejm.org/doi/10.1056/NEJMp1314868>.

²⁸¹ Nelson Sabatini, Joseph Antos, Howard Haft, and Donna Kinzer. "Maryland's All-Payer Model—Achievements, Challenges, And Next Steps." *Health Affairs*, January 31, 2017. <https://www.healthaffairs.org/doi/10.1377/hblog20170131.058550/full/>.

provided the impetus in the early 2010s for Maryland to implement global budgeting on top of its all-payer system.

This new model was designed to avoiding the cost shifting that occurred under all-payer alone. Maryland set a goal of limiting per capita Medicare hospital cost growth to no higher than the state's projected long-term annual economic growth rate of 3.58%.²⁸² Maryland beat its projected health cost growth goal by several percentage points, saving \$178 million in 2016. In fact, Maryland bested the national hospital spending growth rate by 4.6 percentage points.²⁸³ Building on this success, Maryland policymakers are considering expanding the all-payer global model to other aspects of the healthcare system, potentially saving even larger sums of money.²⁸⁴

Budget Effects

The Medicare Part A Trust Fund is due to run out in 2026, which would cause an immediate 10% cut in Medicare Part A Hospital Insurance funding.²⁸⁵ Before action is taken to shore up this problem, policymakers should observe whether these coverage expansions and payment reforms improve Medicare's finances. Under current law, raising the Medicare payroll tax by an additional 0.80 percentage points would likely close, at least on paper, the 75-year projected funding gap.²⁸⁶ Putting health spending on a sustainable path allows federal policymakers to spend money on other national priorities such as Social Security solvency, education, and the military, among others.

²⁸² Ibid

²⁸³ Ibid

²⁸⁴ Ibid

²⁸⁵ Paul Van De Water. "Medicare is Not "Bankrupt"." *Center on Budget and Policy Priorities*, July 3, 2018. <https://www.cbpp.org/research/health/medicare-is-not-bankrupt>.

²⁸⁶ Ibid

Considering that Medicaid accounts for 29% of state budgets on average, this plan would also free up funds for other priorities at the state level.²⁸⁷

Political Analysis

Stakeholder Analysis

As discussed in the *History and Background* section, the primary stakeholders in any healthcare debate are the consumers, producers, providers, and payers. Below is an exploration of how each of these groups might be affected by and respond to this policy proposal.

The Consumers

As discussed earlier, healthcare consumers are also voters. They're sensitive to healthcare costs and quality but also to ideology and politics. Their influence is felt primarily by policy makers through voting behavior and indirectly via interest group pressure. In the healthcare space, nonprofit groups such as AARP and Families USA advocate on behalf of consumers, seeking to expand coverage and ensure existing plans are adequate. These groups tend to be more liberal-leaning and would likely support this proposal, potentially leveraging their grassroots networks and engaging in issue advertising to aid its passage.

In order to gauge potential public support for this policy proposal, the author conducted a quantitative analysis of polling data from the Pew Research Center's 2018 survey of

²⁸⁷ Paige Cunningham. "The Health 202: States scramble to head off future Medicaid shortfalls." *The Washington Post*, February 21, 2019. https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/02/21/the-health-202-states-scramble-to-head-off-future-medicaid-shortfalls/5c6db0641b326b71858c6bec/?noredirect=on&utm_term=.e811d1bedb54.

Americans' political views.²⁸⁸ The Pew survey data allows comparisons to be made between voters' political identities and ideologies and their potential support for healthcare reforms similar to those proposed in this memo. To explore these relationships, the author conducted crosstabs analyses using *SPSS Statistics*. Insights gleaned from the Pew survey are interspersed with analysis from other sources, as noted.

Party identification is a voter characteristic often used in political studies, but this metric has limited explanatory power. Many people self-identify as independents but when forced to choose—as in an election—will support either Democrats or Republicans.²⁸⁹ And since Donald Trump was elected in 2016, the number of people identifying as Republicans has significantly decreased, while self-described independents have become more common.²⁹⁰ Given these realities, a better way to measure overall political preferences is to ask voters which of the two major parties they would lean towards if forced to make a choice. In the survey used for this analysis, Pew combined this “leaner” metric with a measure of ideology determined by a battery of questions. The variable assembled from this data, called “leaned party identification and ideology,” was used as the independent variable for this analysis, while data from questions about Americans' views on healthcare were used as the dependent variables.

Whereas the Gallup polling cited in the *History and Background* section points to broad public dissatisfaction with the U.S. healthcare system, the author's analysis of the Pew data suggests that a majority of Americans believe the federal government should act to

²⁸⁸ “September 2018 Political Survey.” *Pew Research Center*, October 4, 2018. <https://www.people-press.org/dataset/september-2018-political-survey/>.

²⁸⁹ Samara Klar and Yanna Krupnikov. “9 media myths about independent voters, debunked.” *Vox*, January 22, 2016. <https://www.vox.com/2016/1/22/10814522/independents-voters-facts-myths>.

²⁹⁰ Sam Petulla. “People are defecting from the GOP. But not to the Democrats.” *CNN*, February 15, 2018. <https://www.cnn.com/2018/02/14/politics/fewer-republicans-more-independents-no-parties/index.html>.

improve it.²⁹¹ Among all voters surveyed, 57% believed the federal government should be responsible for ensuring universal coverage.²⁹² The vast majority of Democrats—79% of moderates and 92% of liberals—agreed, compared with just 30% of Republicans.²⁹³ An ideological breakdown of the Republicans surveyed reveals that while only 16.5% of conservatives supported a robust government role in healthcare, this figure rose to 45.4% among moderate Republicans.²⁹⁴ That said, moderate Republicans comprise only 14.5% of the electorate compared with conservative Republicans, who make up 30.7%.²⁹⁵

When given the choice between the status quo mix of private and public payers and a single national insurer, a slight majority of 53% chose the government-run “single-payer” option.²⁹⁶ A crosstab analysis revealed that 67% of liberal democrats, 51% of moderate Dems, 38% of moderate Republicans, and 29% of conservative Republicans would support single payer.²⁹⁷ Surprisingly, given their typical preference for limited government, conservative Republicans were nearly twice as likely to support the specific policy of single payer as to support the broad goal of government intervention to achieve universal health coverage.²⁹⁸ One explanation for Republicans’ relative openness to nationalizing private insurers might be that voters have an even lower opinion of health insurance companies than they do of the federal government. A 2009 Gallup poll showed

²⁹¹ Justin McCarthy. "Seven in 10 Maintain Negative View of U.S. Healthcare System." *Gallup*, January 14, 2019. <https://news.gallup.com/poll/245873/seven-maintain-negative-view-healthcare-system.aspx>.

²⁹² “September 2018 Political Survey.” *Pew Research Center*, October 4, 2018. <https://www.people-press.org/dataset/september-2018-political-survey/>.

²⁹³ Ibid

²⁹⁴ Ibid

²⁹⁵ Ibid

²⁹⁶ Ibid

²⁹⁷ Ibid

²⁹⁸ Ibid

that "insurance company greed" was the third-most cited problem with the healthcare system, after high costs and the belief that too many people were uninsured.²⁹⁹

A recent survey by the Kaiser Family Foundation also found that a majority of Americans supported single payer, but when respondents were told about the large tax increases required, they become less supportive.³⁰⁰ This isn't an entirely rational opinion, considering that U.S. workers are effectively taxed at rates nearly equivalent to European workers, if premiums and other out-of-pocket costs are included.³⁰¹ In fact, single payer advocates argue that it shouldn't matter to consumers whether their money is going towards the federal government or private insurance companies.³⁰² But from a behavioral economics perspective, operationalizing universal healthcare requires an acknowledgement that humans aren't rational.³⁰³ Americans are used to paying a certain amount of taxes and a certain (though rising) amount for their healthcare. If all consumer health spending was immediately replaced with taxes, many people might perceive they were paying more, even if they actually saved money overall. The proposal laid out in this memo would address concerns about costs to taxpayers by co-opting existing funding streams as much as possible, preserving limited cost-sharing, and channeling some healthcare spending into private supplemental plans. As a result, the tax increases required for AmeriCare are dwarfed by the costs needed for single payer, making this proposal more palatable to voters.

²⁹⁹ "Healthcare System," *Gallup*. 2009. <https://news.gallup.com/poll/4708/healthcare-system.aspx>

³⁰⁰ Ashley Kirzinger, Cailey Muñana, and Mollyann Brodie. "The Public On Next Steps For The ACA And Proposals To Expand Coverage." *The Kaiser Family Foundation*, January 23, 2019. <https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2019/>.

³⁰¹ Matt Bruenig. "US Workers Are Highly Taxed If You Count Premiums." *People's Policy Project*, April 8, 2019. <https://www.peoplespolicyproject.org/2019/04/08/us-workers-are-highly-taxed-when-you-count-health-premiums/>

³⁰² Ibid

³⁰³ Derek Thompson. "Richard Thaler Wins the Nobel in Economics for Killing Homo Economicus." *The Atlantic*, October 9, 2017. <https://www.theatlantic.com/business/archive/2017/10/richard-thaler-nobel-economics/542400/>.

The same Kaiser Family Foundation survey found that voters were much less likely to support single payer when they found out that they would lose their current health insurance.³⁰⁴ The reality is that most ESI-covered Americans are satisfied with their insurance (70% in 2018, according to an industry survey).³⁰⁵ However, this level of satisfaction may change as more workers with ESI become “underinsured” due to the high deductibles and other out-of-pocket costs cited earlier in this memo. In acknowledgement of these concerns about coverage disruption, this proposal would not immediately change most Americans’ health insurance plans, instead allowing companies and employees to choose the new public plan as they see fit.

Medicare is incredibly popular among beneficiaries and non-beneficiaries alike.³⁰⁶ The new long-term care component and the changes to provider payments would save consumers money and make the program even more popular. But the over-65 population which relies on Medicare may be skeptical of attempts to use the program as a vehicle for expanding coverage to all Americans. Furthermore, Medicare beneficiaries are nearly all older Americans, the age group which votes at the highest rates.³⁰⁷ And so, expanding Medicaid and the ACA rather than Medicare avoids a potential conflagration with older Americans at the ballot box. Preserving Medicare also allows AmeriCare to take advantage of the fact that the percentage of Americans enrolled in Medicare will increase

³⁰⁴ Ibid

³⁰⁵ Thomas Beaton. "71% of Workers Satisfied with Employer-Sponsored Health Plans." *Health Payer Intelligence*, February 8, 2018. <https://healthpayerintelligence.com/news/71-of-workers-satisfied-with-employer-sponsored-health-plans>.

³⁰⁶ Mira Norton, Bianca DiJulio, and Mollyann Brodie. “Medicare And Medicaid At 50.” *Kaiser Family Foundation*, July 17, 2015. <https://www.kff.org/medicaid/poll-finding/medicare-and-medicaid-at-50/>.

³⁰⁷ Dena Bunis. “The Immense Power of the Older Voter.” *AARP*, April 30, 2018. <https://www.aarp.org/politics-society/government-elections/info-2018/power-role-older-voters.html>.

by 4 points by 2025 due to the aging of the population.³⁰⁸ This lowers the new revenues needed to fund AmeriCare by approximately \$167 billion in 2025, when the program would be fully implemented.³⁰⁹ A budget gimmick, perhaps, but anything that lowers the cost of an expensive proposal will only help its chances of becoming law.

As discussed in the *Policy Analysis* section, the policy argument for shifting Medicaid long-term care spending to Medicare is sound. However, this proposal carries political risk. First of all, during implementation of the new program, payment for some individuals' long-term care might appear to be or actually be temporarily disrupted. Furthermore, during the debate over repealing the Affordable Care Act in 2017, Medicaid's role providing vital coverage for both children and older people likely had a politically protective effect on the program.³¹⁰ However, as this proposal would consolidate all health spending on older people into Medicare, the inheritor of Medicaid (i.e. AmeriCare) could become less politically resilient as it no longer would benefit seniors. On the upside, because people of all income levels could be covered under AmeriCare, it would no longer be perceived as a program catering solely to low income people and therefore a target of opportunity for budget cuts.

Ultimately, this analysis highlights the potential for a bipartisan coalition between Democrats and moderate Republicans on comprehensive healthcare reform. A majority

³⁰⁸ "The Next Generation of Medicare Beneficiaries." *The Medicare Payment Advisory Commission*, June 2015. <http://www.medpac.gov/docs/default-source/reports/chapter-2-the-next-generation-of-medicare-beneficiaries-june-2015-report-pdf?sfvrsn=0>.

³⁰⁹ NHE Tables." *Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, 2019. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip>.

³¹⁰ Aviva Aron-Dine and Matt Broaddus. "Latest Republican ACA Repeal Plan Would Have Similar Harmful Impacts on Coverage and Health as All the Others." *Center on Budget and Policy Priorities*, June 20, 2018. <https://www.cbpp.org/research/health/latest-republican-aca-repeal-plan-would-have-similar-harmful-impacts-on-coverage-and>.

of Americans are dissatisfied with the healthcare system and open to the federal government playing a larger role. However, the polling cited in the *History and Background* section shows that when actual legislation is introduced, and messaging campaigns arise on both sides, broad opinions about the healthcare system tend to revert to the political mean.³¹¹ In short, politicization can polarize opinions of policies that originally had bipartisan support, potentially turning an uphill battle into a doomed effort.

The Payers

The federal and state governments as well as employers, who finance a large percentage of U.S. healthcare costs, would likely support this policy proposal. As discussed in the *Policy Analysis* section, if the cost control proposal were fully implemented, rising healthcare costs would no longer squeeze government budgets, allowing other funds to be shifted to other priorities. Similarly, employers would no longer be saddled with providing increasingly expensive health benefits. They could increase their revenues or less likely, raise wages for workers.

Unlike these other payers, private insurance companies would be dramatically affected by this policy proposal, which diminishes and potentially eliminates the role of private companies as primary insurers. Considering that AHIP spent millions of dollars to oppose the ACA, which was relatively private insurance-friendly, the trade group would presumably wage an even more robust campaign against AmeriCare.³¹² In fact, insurance companies have already united with the pharmaceutical industry to create a joint

³¹¹ Justin McCarthy. "Seven in 10 Maintain Negative View of U.S. Healthcare System." *Gallup*, January 14, 2019. <https://news.gallup.com/poll/245873/seven-maintain-negative-view-healthcare-system.aspx>.

³¹² Rick Ungar. "Busted! Health Insurers Secretly Spent Huge To Defeat Health Care Reform While Pretending To Support Obamacare." *Forbes*, June 25, 2012. <https://www.forbes.com/sites/rickungar/2012/06/25/busted-health-insurers-secretly-spent-huge-to-defeat-health-care-reform-while-pretending-to-support-obamacare/#1b1508fe4248>.

advocacy group opposing the types of single payer proposals being floated by progressives.³¹³

Under AmeriCare, the private industry would not be outright eliminated. Many employers might continue to provide private coverage for years and the private supplemental plans would ensure some revenue for private insurance companies. There is an argument for eliminating private insurance outright, because the industry will wage an all-out campaign against the legislation whether it is regulated out of existence or just marginalized. However, the potential benefits of supplemental plans to consumers, including the effects on drug innovation, outweigh this consideration.

The Providers

Because this proposal would result in reduced payments to hospitals, doctors, and other health providers, it would likely inspire intense opposition from those stakeholders.

Though it might sound like SGR with extra steps, this system of multi-stakeholder negotiation could cultivate buy-in by bringing all types of health providers to the table. In comparison, Medicare and Maryland's all-payer system use academically rigorous but top-down approaches to rate setting, potentially alienating providers.

Most physicians already report they are not satisfied with their current levels of compensation.³¹⁴ This does not bode well for creating buy-in among doctors to receive lower reimbursements for care and therefore lower salaries. As discussed in the *History and Background* section of this memo, doctors have actively opposed reforms that would

³¹³ Peter Sullivan. "Fearing 'blue wave,' drug, insurance companies build single-payer defense." *The Hill*, August 10, 2018. <https://thehill.com/policy/healthcare/401169-fearing-blue-wave-drug-insurance-companies-build-single-payer-defense>.

³¹⁴ Susan Morse. "Less than half of physicians are satisfied with their compensation." *Healthcare Finance*, June 14, 2017. <https://www.healthcarefinancenews.com/news/less-half-physicians-are-satisfied-their-compensation-poll-finds>.

increase the government's role in healthcare, with the exception of the ACA.³¹⁵ In fact, the AMA has a close relationship with pharmaceutical companies, to whom it sells provider profiles that allow drug companies to better target their marketing to doctors.³¹⁶ This scheme earned the AMA \$20 million in 2000, a figure which is likely much higher today.³¹⁷ Conversely, nurses and other increasingly-utilized health providers have less of a stake in the existing structure. Also, realigning overall reimbursement rates would have a smaller impact on nurses and other providers who already receive lower rates, including providers in areas with large Medicaid populations. This proposal's design acknowledges that slowing growth in reimbursement levels would be more palatable to providers than making immediate cuts. Providers also might be more willing to accept lower reimbursement growth if medical education wasn't so expensive.³¹⁸ Perhaps policies could be enacted to help providers pay down their medical debts or decrease the cost of education for future students. Also, during the debate over the ACA, Democratic lawmakers considered using malpractice reform as a bargaining chip to win over skeptical doctors.³¹⁹ This could be replicated to help garner support for AmeriCare. Hospitals likely would not support this proposal, because capping rates would severely impact their revenues. According to Gerard Anderson, a professor at the Johns Hopkins Bloomberg School of Public Health, hospitals would oppose single payer proposals (and

³¹⁵ Judith Graham. "‘Like a slap in the face’: Dissent roils the AMA, the nation's largest doctor's group." *Stat News*, December 22, 2016. <https://www.statnews.com/2016/12/22/american-medical-association-divisions/>.

³¹⁶ Sheryl Gay Stolberg and Jeff Gerth. "High-Tech Stealth Being Used To Sway Doctor Prescriptions." *The New York Times*, Nov 26, 2000. <https://www.nytimes.com/2000/11/16/us/high-tech-stealth-being-used-to-sway-doctor-prescriptions.html>.

³¹⁷ Ibid

³¹⁸ Caroline Claire Elbaum. "The Price We Pay: How the Cost of Medical School Contributes to US Healthcare Disparities and Spending." *Tufts University*, April 9, 2017. <https://sites.tufts.edu/cmph357/2017/04/09/the-price-we-pay-how-the-cost-of-medical-school-contributes-to-us-healthcare-disparities-and-spending/>.

³¹⁹ William M. Sage and David A. Hyman. "Let's Make A Deal: Trading Malpractice Reform For Health Reform." *Health Affairs*, January 2014. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0006>.

presumably all-payer) because they “are going to look for their bottom line as they always have... if they are going to be worse off, they are going to complain and they will argue that patient safety and patient access will decline.”³²⁰ That said, one benefit of this proposal for hospitals would be a decrease in uncompensated care. In 2017, hospitals had to absorb \$38 billion in uncompensated care, all or most of which would be paid for under this proposal.³²¹ Although this would not entirely compensate for lower hospital revenues under all-payer, it would certainly help and should be a talking point emphasized with hospitals.

The Producers

As mentioned in the *History and Background* section, PhARMA ultimately didn’t oppose the ACA because the drug industry emerged relatively unscathed from negotiations over the bill.³²² An aide to Sen. Ted Kennedy (D-MA) summed up PhARMA’s position as such: “They were first in line; they were on the winning side; they got a good deal that they could live with and they stuck to it.”³²³ However, the pharmaceutical industry is not likely to be supportive of the proposals included in this memo. As discussed earlier, PhARMA is already aligning itself with insurance companies to oppose expanding the government’s role in healthcare.³²⁴ Making drugs affordable would also negate the need

³²⁰ Paige Winfield Cunningham. “The Health 202: Health-care industry preps offense against Medicare-for-All.” *The Washington Post*, January 22, 2019.

<https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/01/22/the-health-202-health-care-industry-preps-offense-against-medicare-for-all/5c44c7701b326b29c3778c54>

³²¹ “Uncompensated Hospital Care Cost Fact Sheet.” *American Hospital Association*, December 2017.

<https://www.aha.org/system/files/2018-01/2017-uncompensated-care-factsheet.pdf>.

³²² Brett Norman and Sarah Karlin-Smith. “The one that got away: Obamacare and the drug industry.” *Politico*, July 13, 2016. <https://www.politico.com/story/2016/07/obamacare-prescription-drugs-pharma-225444>.

³²³ Ibid

³²⁴ “Partnership Statement On Introduction Of Medicare For All-Style Proposal.” *America’s Healthcare Future*, February 13, 2019. <https://americashealthcarefuture.org/partnership-statement-on-introduction-of-medicare-for-all-style-proposal/>.

for middle-men such as Pharmacy Benefit Managers, further increasing costs savings but creating another opponent of this reform.³²⁵ Medical device companies, given their similar incentives, would presumably align with PhARMA.

As discussed in the *History and Background*, U.S. pharmaceutical costs, though growing unsustainably, do support global innovation in the new drug discovery. One potential solution to this quandary, proposed by Dean Baker of the Center for Economic and Policy Research, would be to provide public incentives for pharmaceutical companies to develop new drugs.³²⁶ According to Baker, \$50 billion per year could replace all patient-derived funding for drug development and “the drugs and medical equipment developed through this process would be immediately available at free market prices... (and) that cost would be quite low.”³²⁷

Political Risk and Reward

If you were elected to the presidency and managed to successfully transforming the U.S. healthcare system, you would secure a place in American history among the likes of Franklin Roosevelt and Lyndon Johnson. Barring any scandals or mismanaged military conflicts, a second term would all but be assured. Even if you are not elected president, as the Senator who helped shepherd this landmark legislation through Congress, you would play an important role in U.S. history.

However, any of the major pieces of this proposal could fail due to the risk factors described in the *Policy Analysis* section (not to mention other factors beyond the author’s

³²⁵ Ibid

³²⁶ Dean Baker. “Drugs are Cheap: Why Do We Let Governments Make Them Expensive?” *Center for Economic and Policy Research*, February 13, 2017. <http://cepr.net/publications/briefings/testimony/drugs-are-cheap-why-do-we-let-governments-make-them-expensive>.

³²⁷ Ibid

imagination). If the cost containment policy failed, the whole law might be delegitimized on the grounds that the higher-than-estimated costs of the coverage expansion would be unaffordable. In fact, even successful implementation of the entire proposal would likely result in a political backlash among ideological conservatives, who are concerned about deficits largely as a proxy for the size of government.³²⁸ As a result, such voters would inherently oppose the expansion of government required to implement both the coverage expansion and cost control elements of this proposal.

As discussed previously, the capacity of the healthcare system—i.e. the number of hospital beds and health care providers—might not keep up the care needs of the newly insured. This increased demand would coincide with decreased supply caused by lower reimbursement rates, resulting in longer wait times and potentially causing broad consumer dissatisfaction with the healthcare system. This occurrence would undermine the reforms and prove critics right.³²⁹ If a scenario like the ACA website crash were to occur, consumers would be understandably frustrated but likely would move on once the problems were fixed. But if the coverage expansion proved unworkable or the government lacked the capacity to implement it, there would be an electoral backlash among consumers. And the politicians elected by these disgruntled consumers would likely call for repeal of the law. Given a catastrophic policy (not political) failure, the designers and chief political advocates of this proposal, including yourself, would be discredited and consigned to an ignominious footnote in the long history of healthcare

³²⁸ “What really happens when you starve the beast.” *The Economist*, July 24th, 2007. <https://www.economist.com/free-exchange/2007/07/23/what-really-happens-when-you-starve-the-beast>.

³²⁹ Kimberly Amadeo. “Why America is the Only Rich Country without Universal Health Care.” *The Balance*, March 12, 2019. <https://www.thebalance.com/universal-health-care-4156211>.

reform in the U.S. In fact, such an occurrence would likely cause significant soul-searching within the Democratic Party over the content of its policy platforms.

The Legislative Process

You must be clear-eyed about the hard political realities involved in passing the largest healthcare system overhaul in U.S. history. One hundred years of health reform efforts illustrate the difficulty of achieving transformative change—even across very different political eras. And so, while today’s level of polarization is not quite unprecedented, its intensely partisan nature has fueled a zero-sum attitude among policy makers, radically diminishing opportunities for cross-party collaboration and undermining existing norms and procedures. As a result, the likelihood of the proposal presented in this memo being passed by Congress—without significant structural reform—is almost zero.

In this post-bi-partisan world, our elected leaders are no longer able to tackle the controversial, impactful issues of the day. Even when the same party controls the presidency, the House, and the Senate by simple majority, truly impactful policies will almost never garner the bipartisan support needed to be passed by a 60-vote supermajority in the Senate (and historically it is very rare for a party to accumulate 60 votes within its caucus).³³⁰

Therefore, our congressional norms and procedures must be updated if our government is to function. And the best way to accomplish this is by eliminating the legislative filibuster. The first step along this path was taken by Senate Majority Leader Harry Reid (D-NV) in 2013 when—in the face of partisan obstruction—he decided to end the

³³⁰ Tom Curry. “Why 60 is the magic Senate number.” *NBC News*, October 27, 2008. http://www.nbcnews.com/id/27372033/ns/politics-decision_08/t/why-magic-senate-number.

filibuster for all presidential appointments, short of nominees to the Supreme Court.³³¹ In 2017, Reid’s successor as Majority Leader, Senator Mitch McConnell (R-KY), eliminated the filibuster for Supreme Court nominees.³³² McConnell had already established that the Senate majority would not vote on a Supreme Court nominee chosen by a president of the opposing party.³³³ And so, if the Majority Leader hadn’t removed the 60 vote threshold, the “world’s greatest deliberative body” might never again have filled an absence on the Supreme Court. This principle also applies to Congressional legislation—unless the filibuster is done away with, Congress will largely cease to be a policymaking body. Elections will barely matter outside of how the executive branch implements existing law and which judges are nominated to the courts.

The clear downside of this strategy is that ending the legislative filibuster cuts both ways. Each party would be able to enact its priorities—and undo the other party’s—during respective bouts of undivided government. Repealing legislation would become much easier without the need for a Senate supermajority. Even seemingly established, longstanding public policies would blow with the winds of elections, potentially imperiling progressive efforts to build a robust social safety net. Ensuring the long-term existence of programs such as those proposed in this memo requires the existence of constituencies willing to fight repeated political battles in defense of these policies. Such constituencies have protected social programs in the past, but without the filibuster this work would become a tall order.

³³¹ Jane C. Timm. “McConnell went ‘nuclear’ to confirm Gorsuch. But Democrats changed Senate filibuster rules first.” *NBC News*, June 28, 2018. <https://www.nbcnews.com/politics/donald-trump/mcconnell-went-nuclear-confirm-gorsuch-democrats-changed-senate-filibuster-rules-n887271>.

³³² *Ibid*

³³³ *Ibid*

An alternative option to circumvent the supermajority requirement is budget reconciliation. However, due to severe constraints in the parliamentary rules, this maneuver generally can't be used to create or expand social programs.³³⁴ Reconciliation helped ensure passage of the ACA, but only because an earlier iteration of the legislation was passed with 60 votes in the Senate. Therefore, the only realistic way to pass this proposal into law would be ending the filibuster in its entirety.

Recommendation

I recommend that you introduce a bill in the Senate reflecting the entire proposal as presented in this memo. I also recommend making it a centerpiece of your presidential campaign. This proposal successfully addresses the twin stated goals of expanding health insurance coverage and putting healthcare spending on a sustainable path.

The national health insurance program proposed in this memo, AmeriCare, would improve Americans' health, productivity, and financial resilience.^{335,336} And ending the patchwork system of health insurance plans would prevent Americans from losing coverage due to a change in life circumstances such as job loss or divorce. Furthermore, anyone covered under ESI would be given the option to smoothly transition to the new public program. This would allow people to see for themselves that AmeriCare is a better deal, rather than being forced to switch plans. This element of choice will contribute to

³³⁴ Dylan Scott. "The Senate's rules will make it really hard to pass Medicare-for-all." *Vox*, March 8, 2019. <https://www.vox.com/platform/amp/policy-and-politics/2019/3/8/18251707/medicare-for-all-bill-senate-filibuster-budget-reconciliation-byrd-rule>.

³³⁵ John McDermott. "Both in rich and poor countries, universal health care brings huge benefits." *The Economist*, April 28, 2018. <https://www.economist.com/special-report/2018/04/28/both-in-rich-and-poor-countries-universal-health-care-brings-huge-benefits>.

³³⁶ Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Samantha Artiga. "The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review." *The Kaiser Family Foundation*, March 28, 2018. <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/>.

building long-term, sustainable buy-in for this proposal. AmeriCare is also less expensive for the federal government when compared to other similar proposals such as Medicare for All, which helps politically in a deficit-conscious environment. The Medicare Part E portion of this proposal was intended to prevent people running out of funds to pay for long-term care. It would likely achieve this goal, alleviating financial burdens on Medicaid as well as on older Americans.

Upon expanding healthcare access to millions of people, there might not be enough health providers to adequately meet the needs of the population. Demand outstripping supply of health providers would lead to much longer wait times, particularly for non-time sensitive care. This problem could be particularly acute in the early years of the program, though comparably longer wait times tend to be endemic to healthcare systems with higher levels of government involvement.³³⁷ The remarkably short wait times for care in the U.S. are not worth preserving in their entirety when weighed against comparably bad health outcomes, a lack of universal coverage and access, and unsustainable cost growth. Private supplementary insurance might contribute to shorter waiting times for some consumers, though creating a two-tiered system might lead to vast differences in care for those of varying incomes.

The decision was made to expand Medicaid rather than Medicare to avoid potential concerns that Medicare beneficiaries' care would be somehow degraded or disrupted under the new framework. However, this creates the risk of AmeriCare losing its politically active older beneficiaries before a new voter constituency can be built around

³³⁷ Kimberly Amadeo. "Why America is the Only Rich Country without Universal Health Care." *The Balance*, March 12, 2019. <https://www.thebalance.com/universal-health-care-4156211>.

the program. AmeriCare also might retain Medicaid's reputation as a program for lower income people, and therefore be more vulnerable to budget cuts. Despite these political risks, this proposal is worth pursuing because of its numerous long-term political and policy benefits.

Healthcare is a business, but it should be well-regulated one. The all-payer global budgeting system proposed in this memo is the best way to put health spending on a sustainable path, freeing the employers, the federal and state governments, and the American people to spend money on other priorities. This approach would lower healthcare costs by setting uniform prices while giving the producers and providers of healthcare a say in how these funds are apportioned. Synchronizing reimbursement rates would also ensure greater access to care for lower income people previously covered by Medicaid.

There are downsides to this approach. Lowering overall drug costs would cut into drug company revenues, potentially decreasing the number of new drugs on the market globally.³³⁸ Another concern about the all-payer global system is that price fixing must be responsive to real world conditions or it could cause overly draconian rate cuts and therefore create provider and drug shortages. The ratemaking body must be prudent in its decision making, considering uncertainty regarding economic growth and the aging of the population. Regulatory capture is also a potential challenge. Political leaders motivated by cost-sensitive consumers will be responsible for ensuring the independence of the ratemaking process. Finally, health producers such as pharmaceutical companies and

³³⁸ Dana Goldman and Darius Lakdawalla. "The Global Burden of Medical Innovation." *The Brookings Institution*, January 30, 2018. <https://www.brookings.edu/research/the-global-burden-of-medical-innovation/>.

providers including hospitals, nurses, APRNs, and doctors would need to adapt to lower prices. Considering the significant political power of the different segments of the healthcare industry, this proposal could cause political risk to the designers of the new system.

I know that you already support ending the legislative filibuster, but I want to reiterate that in our current hyper partisan reality, bold action that may be reversed is preferable to no action at all.³³⁹ Removing the 60-vote threshold in the Senate to enable passage of this healthcare reform proposal is worth the cost of ending of the filibuster. It means that while our grassroots advocates will have to fight twice as hard to preserve policy gains, they will at least have gains to preserve.

Ultimately, the benefits of all facets of this proposal outweigh the downsides—if passed by Congress in its entirety, the country would be healthier, more equitable, and on sounder financial footing, ready to tackle the challenges of the 21st Century.

³³⁹ Eric Lach, “Elizabeth Warren Against the Filibuster.” *The New Yorker*, April 5, 2019. <https://www.newyorker.com/news/current/elizabeth-warren-against-the-filibuster>.

Biography

Logan Ruppel was born in 1990 in New York City. Logan received his Bachelor of Arts in 2012 from the American University in Washington, DC where he majored in Political Science and minored in International Relations. During his undergraduate studies, Logan spent a semester at the American University of Rome, studying public policy from an EU-centric perspective. He began his graduate studies in public management at Johns Hopkins University in the Fall of 2015. Logan has worked on political campaigns and in research roles in the non-profit and private sectors.